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AUTHOR Osborne, Josephine N.
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ABSTRACT

This manual was written to help schools address the problem of youth suicide. The introduction presents a teenager's and a parent's perspective of youth suicide, discusses the problem of youth suicide, and develops a hypothesis of why the problem exists. Section 1 describes the contributing factors involved with adolescent suicide and provides guidelines for identifying students at risk for suicide. Adolescent problems involving depression and substance abuse are given special attention. Section 2 focuses on intervention and makes some suggestions on how adolescent suicide might be prevented in schools. Included in this section are: (1) ways for school personnel, students, and parents to deal with the problem; (2) intervention; (3) a suggested policy for a crisis intervention team; (4) suggested guidelines for schools to use after a suicide or sudden adolescent death; (5) guidelines for recognizing students at risk following a youth suicide; (6) working with the media; (7) handling grief; (8) the Edgewood High School Model for suicide intervention following two suicides in 1985; (9) Indiana chapters of Compassionate Friends; and (10) a national directory of survivor support groups for 1983-1984. A bibliography is included. Fact sheets, a manual evaluation form, and other relevant materials are appended. (NB)

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YOUTH SUICIDE

A SCHOOL APPROACH FOR THE PREVENTION OF YOUTH SUICIDE IN INDIANA

INDIANA STATE BOARD OF HEALTH

CG 019739

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An alphabetical list of the group is on the next page.

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Josephine N. Osborne
Chief Nurse Consultant
Division of Nursing
Indiana State Board of Health

December 1985

ALPHABETICAL LIST OF MEMBERS OF YOUTH SUICIDE GROUP

Facilitator:
Ms. Josephine Osborne, R.N., M.S.N.
Chief Nurse Consultant
Division of Nursing
1330 West Michigan Street
P.O. Box 1964
Indianapolis, IN 46206-1964
317/633-8464

Steve Davis, Ph.D., Coordinator
Student Services
c/o Department of Education
Room 229
State House
Indianapolis, IN 46204
317/927-0241

Ms. Julia M. Haskell, R.N., M.S.
Rensselaer Central High School
Highway 114 East
Rensselaer, IN 47978
219/866-5175

Mr. Jim Killen, A.C.S.W.
Coordinator of Child and Adolescence
Service System Program
Department of Mental Health
117 East Washington Street
Indianapolis, IN 46204
317/232-7888

Ms. Dixie Kline, B.S.
Consultation/Education Services
c/o South Central Mental Health Center
645 South Rogers
Bloomington, IN 47401
812/339-1691

Ms. Patricia McGuffey, B.S.
Director of Childhood Mental Health
c/o Mental Health Association in Indiana
1433 North Meridian Street
Indianapolis, IN 46202
317/638-3501

Donald Orr, M.D.
Director of Adolescent Medicine
James Whitcomb Riley Hospital
Department of Pediatrics
602 Barnhill Drive
Indianapolis, IN 46223
317/264-8812

Jean Pock, M.S.
Indiana Federation of Communities
for Drug Free Youth
60 North First Street
Suite C
Zionsville, IN 46077
317/873-3900

Ms. Cindy Richardson, L.P.N.
5978 North Crandall
Ellettsville, IN 47429
812/876-7800
812/879-4242

TABLE OF CONTENTS

PAGE NUMBER

INTRODUCTION

Youth Suicide: A Teenager's Point of View 1
Youth Suicide: A Parent's Point of View 2
Youth Suicide: An American Affair 6
Facts About Suicide 8

SECTION I IDENTIFYING THE PROBLEM

School Personnel, Students, Parents: Recognize Distress Cues to Suicide 10

Distress Signals for Suicide 11
Adolescent at Risk: Depression 13
Adolescent at Risk: Substance Abuse 18

SECTION II DEALING WITH THE PROBLEM

School Personnel, Students, Parents: Ways to Deal with the Problem 22

Intervention 26

Suggested Policy for the Crisis Intervention Team 31

Suggested Guidelines After a Suicide or Sudden Adolescent Death 33

Guidelines for Recognizing Students at Risk Following a Youth Suicide 38

Working with the Media 39

Grief 43

Edgewood High School Model for Suicide Intervention Following Two Suicides in 1985 44

Indiana Chapters of Compassionate Friends 46

National Directory of Survivor's Support Groups, 1983-84 48

BIBLIOGRAPHY 52

PAGE NUMBER

APPENDIX A. Indiana Adolescent Suicide Fact Sheet, 1984.....54

APPENDIX B. Assessing Suicide Potential in the Classroom.....56

APPENDIX C. Getting Tough on Gateway Drugs.....60

APPENDIX D. Plain Talk About Adolescence.....61

APPENDIX E. Sources of Information.....63

APPENDIX F. Topics from National Conference on Youth Suicide.....68

APPENDIX G. Manual Evaluation Form.....70

YOUTH SUICIDE: A TEENAGER'S POINT OF VIEW

The following was a 16-year-old Indiana boy's impression of youth suicide.

"For each suicide or attempted one, there are many that go unseen...hidden beneath long-sleeved shirts and well-developed excuses. This is what has happened to me recently:

-- Five days ago, a close friend revealed to me the loaded gun he keeps hidden next to his bed.

-- Four weeks ago, I found my best friend's sister at home with both wrists slit. We managed the best cover-up yet. Her mother didn't even suspect anything.

-- The threats, ideas, and discussions are too numerous to mention here. The best way to find out how common the thought of self-destruction is would be to ask the teenagers. They know, they can tell you, and they need to talk even if it means revealing their secrets."

He went on to write the following poem:

16 YR OLD DESPAIR

"Death all around me
Thundering in my ears
Doesn't anyone understand?
We have cause to fear.

Useless it is to strive
Useless it is to survive
When all we hear
Is that death is near

If the best is now?
Why meet the future?"

JEREMY M.,
age 16

YOUTH SUICIDE: A PARENT'S POINT OF VIEW

The following comments were written by a mother who lost her daughter last winter (1985). It is a touching story. Her words have not been altered in any way.

Weeks have passed, yet I still procrastinate in penning my thoughts and experiences for this parents' perspective on teen suicide. The reasons are many, my uncertainties are hundred-fold. I was however, certain my scribblings would be inadequate. How could I describe in mere words the utter sense of waste and loss, the guilt feelings which literally assault me, leaving me weak and breathless? How could I tell you how I grew to hate those ever-present tears that lurk in the corners of my eyes and threaten to fall when it seems everyone is looking? Last of all, where will I get the courage to open the Pandora's box of thoughts and feelings I had buried with my daughter? Please God, don't let this hurt as badly as I'm afraid it will.

Throughout my lifetime, I have accumulated many titles: "Jerry's wife," Amy and Nikki's mom," "June's friend," etc. Now I have another title. It is called a "Survivor of Suicide." I became a "survivor" when my daughter, Amy, killed herself on January 8, 1985. She was fourteen years, five months and one day old. She was beautiful. She was my pride and joy and all she is now - is gone.

Eight months ago, my notion of a teen who attempted or completed suicide was that of a lonely child with above average intelligence who seemed unhappy and had no close friends or family with whom he could share his problems. I imagined he wrote long dreary poems of his inability to fit in with the world such as it is. And when he took his life - no one would be surprised.

It is said, "Ignorance is bliss." Let me tell you now, that ignorance is deadly. Had I not been ignorant of the signs of teen depression and signals of suicide, I would not be a "survivor." I would still be "Amy's Mother."

Amy was one of those loving children who had a kind word for everyone. Our phone was always ringing, our home was full of her friends. She made good grades and was very popular with adults and kids. When she laughed, and she was always laughing, she would throw back her head and let out the most joyous, infectious noise. Those around her would laugh also - without a hint as to what the joke was about. She loved to dance and won many trophies for clogging, a form of Appalachian style folk dancing. Last summer we danced in England, Ireland and Wales. We always had so much fun. She would put her arms around me and say "Mom, I love you. You're my best friend." And I would press my face into her thick dark hair, for it always smelled like spring flowers, and tell her I loved her too.

On the day she died, I came home from work to find several police cars in front of the house and a hearse backing into the drive. I ran into the house and saw my husband and a neighbor crying. My brother, a policeman, was present and told me Amy was dead. I ran into the family room and saw her lying on the floor. Because she had been ill and home from school with asthma problems and the flu, I thought she had died of some kind of complication. No one uttered the word "suicide." The coroner questioned me about a bottle of pills - it was her asthma medicine. They kept asking me if she had been depressed and I was too stunned and confused as to what these questions might have implied. Finally, my 12 year old daughter Nikki came into the room and told me how Amy had died. She had returned home from school and she found her sister dead.

Amy had pulled the car into the garage, turned it on and began to write notes to all of us. (There was a note in the kitchen giving Nikki explicit instructions not to go into the garage until she called me home.) Somehow, for some reason, Amy left the car and managed to get into the house. There she fell, bruised her head and then vomited. She died five feet away from the phone.

I am a nurse, and I never allow a patient to die alone. I sit and hold his hand, and talk to him and offer all of the reassurance and comfort I can give. Yet my daughter, whom I love more than life itself, died alone, with no one to hold her. She said in her note - "Mom, even though I have people who love me, I feel so all alone. I feel as though I have to move on and want you to understand. I know how much you love me, but I have to go. Please don't be mad and please understand." I <u>don't</u> understand. I never will. I only know that I will never bury my face in her hair again and smell spring.

My husband and I decided to be truthful about what happened. We thought our honesty might make more parents understand the importance of tuning in more closely to their children's needs. Instead, we opened ourselves to hurt and humiliation I never thought possible. Rumors of my husband being an alcoholic and my having an affair began floating around. It was discussed and bandied about in our own living room by "friends" after the funeral. There was talk that we worshipped the devil and held spiritual rituals in our home. People I didn't know called on the phone to quote scripture and tell me I would rot in hell. I felt like I was already in hell.

When you lose your child, you want to be close to everything and everyone that was a part of her. Amy was a freshman and in her first year in attending the high school. I realized they weren't as well acquainted with me as the Jr. High School

staff, but I offered to come to the school and talk to the kids. Knowing teen suicides can have a cluster effect was a great worry to me. I also had another worry. At the funeral home I saw many of the kids romanticizing her death. There were three rooms full of flowers, hundreds and hundreds of people, but not one child who realized that death is forever - that you could die because you were angry at your parents but wouldn't be there to watch them suffer - that death is final - that death is the end. I felt strongly about letting these kids know there is nothing romantic about suicide.

When I made my offer, the school principal gave me a polite "no thank you" and then asked if there was truth to the rumor I was calling students together to hold a seance in our home to call back Amy's spirit. It was then I felt relief that Amy couldn't see or hear. She loved her school and the school was allowing her death to become a circus. No one would dispel the rumors by allowing the kids to discuss her death openly. The rumors grew and grew until we couldn't even go to the grocery store without being stared at and talked about. I was not guilty of these things they so openly discussed but they made me ashamed. I thanked God everyday for the many kindnesses and support Nikki received from the Jr. High. They had Amy for three years and knew she wasn't a freak.

Three weeks after Amy died, a classmate she knew slightly, killed himself in the same manner. Tragically, the fumes also took the life of his Mother and Father. The superintendent of schools was quoted as saying the boy killed himself because he was despondent over Amy. Naturally it made both the front page in bold, black outline and made our lives hell. We received so many phone calls from people accusing Amy and her classmate of forming a suicide pact and our family of forming a suicide cult, we had to leave our home for several days until the publicity died down.

Then I received a phone call from the very kind, caring and apprehensive assistant principal at school. Like me, he was concerned about the cluster effect. Another student had made an attempt on her life. He set up a convocation for all high school students with several speakers from Community Mental Health, a minister and myself. He followed it with small group sessions in which the students could talk with Mental Health Counselors. Now everything was out in the open. The rumors died shortly after, and I thank him from the bottom of my heart.

I've been asked to speak in other high schools and to youth groups. I'm honest and open with the students and we cry together. For those who are reluctant to diffuse suicide like the dangerous bomb it is, I would like to tell you I have received many letters - (mostly unsigned) from teenagers in those gatherings that have attempted or seriously contemplated

suicide. They all said the same thing - "After hearing you speak, I don't want to hurt myself or my family like that." It was not my effectiveness as a speaker that changed the minds of these students. It was telling them where to get help, it was throwing suicide on a table to examine, dissect and therefore rob it of the mystery and romance that so often surrounds it. It was letting them see it as it really is - death, finality, nothingness and the ultimate waste.

Cindy Richardson
Ellettsville, Indiana

YOUTH SUICIDE: AN AMERICAN AFFAIR

During 1985, a series of mini-conferences were conducted throughout the State of Indiana with school and public health nurses on how to cope with the perplexing problem of adolescent suicide. This manual is the result of the many comments and expressed needs of these nurses. At this time, little is known regarding adolescent suicide; it is a puzzling problem with confusing dynamics. We know more on how to cope with it than we do about what causes it.

Throughout the following pages, you will find numerous suggestions, guidelines, and facts that have been gathered. In this manual, you will find three major sections. The introduction discusses the problem of adolescent suicide and develops a hypothesis of why the problem exists. Section I describes the contributing factors involved with adolescent suicide and helps you identify students at risk for suicide. Section II focuses on intervention and makes some suggestions on how adolescent suicide might be prevented in schools. An evaluation tool for this manual is in Appendix G. Your feedback will be greatly appreciated.

It has been speculated that adolescent suicide is the result of our changing society. Our youth are frequently faced with unclear or unrealistic expectations from family, friends, and community, as well as ambiguous role assignments and developmental stressors. Contributing to these stressors have been a changing society with a 53 percent divorce rate (1980), 40 percent of households headed by women, schools becoming larger and less personal, and the sexual revolution. These factors find youth floundering and lacking needed support during tedious adolescent years. Some people hold the belief that life was less ambiguous in the past and that the extended family was more available and instructive. Parenting was better defined, and children learned from their families' ways to cope with life. Smaller schools and neighborhoods gave youth a sense of belonging. When failure occurred in one system, remedial responses would occur in another.

Today the social scene is different. The literature attributes the changing society to the changing U.S. economic picture. There is a dramatic shift taking place in the United States from an industrial society to an information and communication society (J. Nesbitt, Megatrends, 1985). The social impact on families is enormous. Parents find it difficult to give the time to their children that the adolescent years require regardless of the socioeconomic status. Families find breadwinners unemployed for the first time in the wage-earners' lives or they find themselves in high-stress jobs. Frequently, there is minimal opportunity for employment if untrained in a skill. Families are stressed. Occasionally, a highly competitive employment environment is all that is available in many industrial cities. All these factors participate in family disruption, confusion, and change. Many adolescents, in trying to identify their place in society, often find no place for themselves.

Complicating the problem further are the tremendous physical, cognitive, and emotional changes that occur during adolescence. It is normally a time of increased insecurity, vulnerability and value confusion.

Maturational stressors challenge the teenagers. The stressors of physical changes are triggered by hormonal changes. Teenagers must learn to adapt to a new body image. Frequently, there is a longing to remain the same and to have the body look as it did. These hormonal changes place greater interpersonal stress on teenagers. The need for intimacy becomes intensified with all of its ramifications. However, ways to achieve this intimacy remain vague and ambiguous in our culture.

Along with the physical changes, youth begin to change cognitively. The ability to abstract begins to develop whereby logical reasoning and complex problem-solving are beginning to be utilized. There might be a big upheaval in the youth's value systems as they begin to question former beliefs. Families, friends, and teachers may find youth somewhat annoying as they often question traditional beliefs at this time.

In the realm of psychosocial adjustments, there is demand at this time to assume an appropriate gender role with responsible sexuality. Academic goals and occupational preparation add to the teenagers' stress. There is pressure to develop an identity as this will affect future adjustment. However, as many persons will say, this is not an easy task since establishing an identity is not always possible due to the many social and economic constraints. In addition, there may be a lot of family and school pressures on the teenagers to be what is not congruent for them or to do better in school than possible. Identity confusion can result--"Who am I?" may become "What do others want me to be?"

When identity confusion occurs, it is common to witness acting out of behavior. This acting out of behavior, like running away from home, dropping out of school, or staying out all night, can be symptomatic of identity confusion. Labeling the youth at this time as "bad" can result in a self-fulfilling prophecy, that is, teenagers may become what others perceive them to be. Further, during identity confusion, they may over-identify with heroes or cliques. When faced with such identity confusion, teenagers may cling together in groups or form groups for support and solid grounding in a group identity. This group identity may not support conformity to school or parental norms.

As a result of these many stressors, many youth are alienated, depressed, and despondent. Many in their youthful thinking imagine a glorious death, a heart-breaking funeral where family and friends gather to share their grief and guilt, and a magical reincarnation. The end result is tragic. The end result may be death!

In addition, a fact sheet that can be copied for distribution is provided in Appendix A.

FACTS ABOUT SUICIDE

Out of 10 people who kill themselves, eight have given definite clues to their intentions. Suicide threats must be taken seriously.

Research shows that the suicidal person gives many clues and warnings. Recognizing these cries for help can save a life.

Most suicidal people are undecided about living or dying. They "gamble with death," leaving it to others to save them. Almost no one commits suicide without letting others know how he is feeling. Often, this "cry for help" is given in code.

Happily, most teenagers who want to kill themselves are "suicidal" for only a limited time. If saved from self-destruction, they can go on to lead useful lives.

Most suicides occur within about three months following the beginning of "improvement"--when the teenager has the energy to put morbid thoughts and feelings into action. Relatives and physicians should be especially vigilant during this period.

Suicide is neither a rich man's disease nor a poor man's curse. It is common through all levels of society.

Suicide does not run in families. It is an individual matter and can be prevented. However, the suicide of a family member can have a profound influence on others in the family.

Stories of hundreds of genuine suicide notes indicate that, although the suicidal person is extremely unhappy, he is not necessarily ill. His overpowering unhappiness may result from a temporary emotional upset, a long and painful illness, or a complete loss of hope.

"One of the facts about which we are fairly sure (about youth suicide) is the compelling research evidence supporting the relationship between increases in the suicide rate and the periods of increasing birth density (baby booms)...research continues to show those who make very serious efforts to end their lives are often the brightest and most achievement oriented youth in our society." (K. Smith, Ph.D., in Suicide and Suicide Prevention, U.S. Government Printing Office, 1985, p. 57).

The problem is that American youth are in trouble. Substance abuse and sexual promiscuity are on the increase. Teenage pregnancy remains a problem, and youthful runaways are rampant in many cities. Prisons are bulging with young adults, and crime is increasing in many American towns. What is happening to our youth? What will happen to us? It is time for us to take stock of our state of affairs and recognize that schools can be a major springboard in bringing stability out of chaos and helping our youth. School staff are frequently the most <u>available</u> adults in many of the lives of our youth. They can be alert to troubled students and provide the guidance that is needed in these turbulent, transitional times.

Clearly, as we become more technological as a society, we must strive to maintain our human dignity and our emotional attachment to one another...it is the needed balance. As our society changes, so must our social institutions.

SECTION I

IDENTIFYING THE PROBLEM

SCHOOL PERSONNEL, STUDENT, PARENTS: RECOGNIZE DISTRESS CUES TO SUICIDE

What can school personnel, parents, and students do to change the tide of youth suicide? Initially they can be alert to the cues to suicide. The distress signals are youth's way of letting us know they need help. Seldom do young people recognize their own difficulty or bother to consult with adults. What they do, however, is send out camouflaged signals. You need to recognize the importance of those signals. Confront the youth regarding your observations, validate with a member on the crisis team (see page 22 in this manual), and get help for the youth. The formation of a crisis team at your school is another way to help prevent youth suicide. A more thorough discussion of the team's role and function occurs later in this manual.

The following distress signals are not listed in hierarchial order. It cannot be said that one signal makes a youth suicidal. There is never just one thing that brings about a suicidal adolescent. It is the accumulation of many factors. It can be the loss of a loved one like a boyfriend or girlfriend, failure in a class, rejection from a club, argument with a parent, and/or trouble with the police. It seems that loss, real or perceived, characterizes the youth's life. The youth needs help. Further, if parents, peers, and all school personnel learn to identify these distress signals, many young lives can be saved.

DISTRESS SIGNALS FOR SUICIDE

Acting out: aggressive, hostile behavior, truancy, cutting classes

*Abrupt changes in personality

*Sudden mood swings (sudden positive behavior following a period of especially serious depression)

*Giving away prized or personal possessions

*Obsession with death; a death wish; death themes in drawings and poetry

*Discussion of suicide or making a suicidal plan

Accident prone

Alcohol and drug abuse

Passive behavior

Changes in eating habits

Changes in sleeping habits

Fear of separation

Impulsiveness

Slackening interest in school work and decline in grades

Inability to concentrate

Loss or lack of friends

Loss of an important person or thing in the child's life

*Hopelessness, helplessness, and anger at self and the world

Writing a lot of letters to friends

*Previous attempt!!

*Scratching, self-mutilation, or other self-destructive acts

*These cues are indicative of a high potential for suicide, particularly if depression and/or substance abuse is present.

Youth who are at risk are those who are depressed, abusers of drugs and/or alcohol, runaways, homeless and/or abused children (sexual or physical), products of broken homes, or displaced youth (military or recent geographical move). Many of these factors contribute to youthful suicide. However, many suicidal youth have two characteristics that are frequently present, depression and/or substance abuse. The early recognition of depression and substance abuse can help reduce the number of suicide attempts. Because of space limitations, these two topics will be discussed only briefly. In Appendix F, you will find a list of audiotapes from the first National Conference on Youth Suicide that can provide you with information not covered in this manual.

ADOLESCENT AT RISK: DEPRESSION

Teen Depression

Novelists, poets, and dramatists throughout Western history have described the agony and anguish of depression. Depression is a common malady of the elderly but is now recognized to be as common, if not more common, in the 20-40 age range. Depression can lead to suicide. Fifty percent of depressed children say they have seriously thought about hurting themselves (NIMH 1980), and less than one in three seek treatment for their depression. It needs to be emphasized that no single cause seems to be related to clinical depression, it is a multidimensional, multicausal problem with family dynamics, family history, and genetics playing major roles.

For whatever reasons, depressed adolescents feel as though they cannot communicate with their parents or significant others. They feel isolated and alone when they desperately need to seek attachments and intimacy. However, they frequently lack the necessary social skills to develop the types of relationships they so desperately need. Further, it has been speculated that depressed adolescents tend to have a negative interpretation of events and themselves, perceiving themselves as failures. Because of this failure, they feel guilty. They are filled with self-reproach and self-hatred, and have a negative view of the future.

When discussing depression, it is important to distinguish it from the normal mood swings experienced by teens. What distinguishes depression from the normal mood variation is the DURATION AND INTENSITY of symptoms. If the following symptoms last for at least two weeks or if there is impairment in normal functioning, a depressive disorder might be present. The list contains symptoms of depression and the starred items are masked symptoms of teenage depression.

SYMPTOMS OF DEPRESSION IN YOUTH

*Feelings of emptiness in life, loss of interest in usual activities

*Risk-taking behavior (driving fast, recklessly)

*Rebellious refusal to work in class or cooperate in general

Sadness (in children under six years of age, may be inferred from a persistently sad facial expression)

Anger and rage--typically expressed by verbal sarcasm and attack (angry outbursts)

Inability to concentrate or make decisions

Sensitivity with inclination to overreact to criticism

Fluctuations between indifference and apathy on one hand and talkativeness on the other

Feelings of insufficiency to satisfy ideals

Poor self-esteem (self-criticism and blame, sense of personal failure)

Feelings of helplessness and decreased peer support

Withdrawing from friends, excessive television watching

Intense ambivalence between dependence and independence

Restlessness and agitation (inability to relax)

Mood swings--the quiet youngster becoming hyperactive, the outgoing youngster becoming withdrawn

Pessimism about the future

Death wishes; suicide ideas, plans, and attempts

Sleep disturbance (decreased or increased)

Increased or decreased appetite

*Weight gain or loss (anorexia)

*Somatic problems (e.g., headache, stomachaches)

Studies have shown that depressed teenagers suffer significant sleep disorders. These sleep disturbances like excessive sleeping, early morning awakenings, or problems with falling asleep at night may go on for weeks and are different from the inability to fall asleep because of high anxiety or anticipating a scary event.

Appetite is usually decreased in depressed teenage women and can develop into the severe disorders of anorexia or bulimia.

As impairment in job performance happens in adults, impairment in the teenager's "job" (school) is similar and significant. Depressed teenagers find previously enjoyable activities as "boring." Lowered grades in school and withdrawal from previously enjoyable activities are significant events that might be related to the teenager's depression.

Further, masked depressions are disguised with behaviors puzzling to those around the youth. It often manifests itself in disobedient behavior in school and at home. This masking or change of behavior is misunderstood by others and viewed as "just a phase" or a deviancy rather than an indication and warning that depression actually exists. Intervention is needed--the class clown on the outside may be hurting on the inside, and the verbally abusive student may be "biting his tongue" elsewhere. Those teenagers need help!

Personal drug/alcohol use may be present in depressed youth, but usually it is a symptom and not the cause of depression. Problems existed before drug use began and substance abuse may be a form of self-medication to alleviate depression.

TIMES OF DANGER AND RISK FOR DEPRESSION

During rites of passage (graduation from school, completion of parents' divorce, because of loss of a parent's daily presence, or leaving home to go to college)

Anniversaries of unhappy events (parent death, severe losses, etc.)

Holidays, particularly family holidays if family is split up

Vacation times, especially if young person is isolated

Change of seasons (some depression surfaces in winter, for instance)

Depressed teenagers may withdraw into fantasy and develop romantic ideas of death. This romantic response to death will mask its cold reality and absolute finality.

recent, major loss, like a break-up with a girlfriend or boyfriend, failure in a class, or change in body part/function

loners

those who lack social skills

over-achievers

learning-disabled and under-achievers

those under pressure

new students

adopted children with inadequate family bonding; blended families (step-children) with inadequate family bonding

IT IS IMPORTANT TO NOTE THAT THESE CHARACTERISTICS ARE OFTEN COMBINED WITH ONE OR MORE OF THE FOLLOWING:

poor parent/child relationships

absent parents

divorced or divorcing parents

internal family conflict, either between parents or siblings

conflict in blended families

financial problems, breadwinner in family unemployed

cultural changes

member of minority

personal pathologies

- obsessions
- fantasies
- unrealistic fears
- little impulse control

family pathology

- one or both alcoholic parents
- depressed parents
- abusive parents
- mentally ill parent or parents
- suicidal parent

Adapted from Kinzey, Dorothy, 1984

As you can see, symptoms of depression in youth are very similar to symptoms of suicidal behavior. They go hand-in-hand. However, not all depressed youth commit suicide nor are all suicide attempts a reaction to depression. Sometimes the impulsiveness of youth, along with youth's limitations in life's experiences, finds its expression in suicidal behavior.

Features to Remember

It is important to remember that when depression seems to disappear and is replaced by a sense of calm--especially with no change in circumstances--the depressed person is more at risk for suicide. Until that time, he/she may not have had the "energy" to carry out suicide plans. Keep the following facts in mind regarding depression in youth:

The problem student who seems to remain in trouble (truancy, sexual promiscuity, runaway) may be suffering from a masked depression, particularly if substance abuse is present. What losses did the youth experience in his/her lifetime?

Anyone with signs and symptoms of depression should be seen by a physician or a mental health professional. A doctor should be able to recognize depression and prescribe proper treatment--either through psychotherapy or medications or a combination of those.

Depression is the "common cold" of mental illnesses and with proper treatment the success rate of overcoming it is very high. It is usually responsive to proper treatment. By being alert to depression, a lot of tragedy can be prevented. Young lives can be saved!

ADOLESCENTS AT RISK: SUBSTANCE ABUSE

There are no guarantees, no "sure-fire" ways to keep a youth off drugs/alcohol, but many agree that the family is the child's best defense against drugs. The reasons teenagers do drugs/alcohol are many and cannot be described simply. Certainly an obvious one is curiosity. We do know that many adolescents who commit or attempt suicide have been involved with substance abuse. Many times they may have taken alcohol or drugs to muster up the courage to kill themselves. Generally, it has been found that adolescents who commit suicide have taken some drugs during the 24 hours preceding the suicide.

It has been well documented that the leading cause of death for 15 to 24-year olds is automobile accidents and that 70 percent of those fatal auto accidents are drug/alcohol related. Considering that 74 percent of all high school students drink, there is cause for alarm. It is difficult, if not impossible, to determine exactly how many suicide attempts are drug/alcohol related, as complete investigations are not always performed to determine the presence of drugs/alcohol. As a result, the figures that are reported are believed to be conservative, and one must be skeptical of their accuracy.

Drug/alcohol users are definitely at risk for suicide for several reasons. While users, when not experiencing a "high," may appear to be well-adjusted or "together" nonsuicidal persons, they become suicidal during a "high" if for no other reason than that the drug will remove normal inhibitions and impair judgment.

How do you tell if a youth is using drugs/alcohol?

Clues may not always be obvious or conclusive. However, the presence of any of the following characteristics should be considered enough to warrant further investigation. These characteristics are common in most substance abusers.

1. Appears to be "changing," becoming more irritable, secretive, unpredictable, hostile, depressed, uncooperative, apathetic, withdrawn, sullen, easily provoked, and over-sensitive.

2. Appears less "responsible": tardy for school, forgetful, not completing homework, chronically absent or dropping out of school, lying, and stealing.

3. Changes friends, appearance, interests; less interested in school, sports, or activities; more interested in rock concerts and music.

4. Difficult to communicate with: refuses to talk about friends, drugs; defends friends, feels hassled, defends rights of youth; points out bad habits of parents/adults.

5. Shows physical and/or mental deterioration. The physical/mental effects of drugs/alcohol are many and may vary from drug to drug. Users may exhibit a few or many of the symptoms as individuals vary in response to substances.

Two popular drugs among youth are alcohol and marijuana. Symptoms of their use are included. Since cocaine use is on the increase, it is also included.

a. Alcohol Use

Changes in habits or activities, absent from school from unaccountable reasons.

Slipping grades and missed assignments.

Change in friends.

Cannot remember what happened at a party--blacks out.

Requesting money more frequently from parents/friends or caught stealing.

Rumors are spreading about youth's partying or drinking.

Parents may have noticed their liquor supply at home is disappearing.

Family may have experienced an unusual amount of stress like unemployment, geographical move, loss of a child, or divorce.

There may be a history of alcoholism in the family.

An important point about teenage drinking is that it is usually episodic and binge drinking. This can be serious because of alcohol's toxic effect on the body. Overdose from alcohol can result in death, a serious side effect that many youths forget. Negative consequences of intoxication, like driving performance, accidents, aggression, and violence are cause for alarm because of its negative consequences on the youth's family and friends. Further, the young, inexperienced teenager may develop serious physical problems from alcohol abuse. This author remembers a 14-year-old girl who was hospitalized from alcohol abuse of only "eight weeks duration," and she had the beginning stages of cirrhosis of the liver (alcoholic hepatitis).*

b. Marijuana Use

Disordered thinking or ideas and thought patterns that seem out of order.

Heightened sensitivity to touch, smell, taste.

Increased appetite after marijuana smoking (known as the "munchies").

*Problem is greater in girls and before puberty. (Dr. James Brown, Fairbanks Hospital, Indianapolis, IN)

Loss of ability to blush.

Decreased ability for rapid thought processes.

Amotivational syndrome.

Weight loss.

Lack of signs of maturation, such as facial hair, muscle development, etc., due to decrease in testosterone (male users).

Impaired motor coordination and perceptual ability to follow a moving object or detect a flash of light. (DuPont, Robert L., M.D.)

c. Cocaine Use

Runny nose, the tissue of which is at least irritated, if not scarred, from snorting.

Bloody coughs.

Needle marks.

Seizures.

Hoarseness.

Eyes sensitive to light, double vision, image distortion or "floating spots."

High temperature.

"Shakes."

Depression.

Extreme fatigue.

The drug user may leave in plain view or hide their paraphernalia depending on what drug(s) they are using. Paraphernalia may be as innocent looking as a Coca Cola can, a belt buckle, a pen, a Frisbee, feathers with a clip on the end, trays, aluminum foil, cardboard tissue paper rolls, miscellaneous nuts and bolts, mirrors, razor blades, straws, film canisters, matchbooks with burned spots, incense or aerosol deodorizers (used to mask smell of marijuana), or paraphernalia may look like plastic freestanding cylinders with small hoses attached (bong), toy "space guns," etc. Magazines, such as High Times, are published by pro-drug groups. They market paraphernalia and publish articles on "gardening" marijuana, how to get better highs, and they name celebrities who recommend drugs. Marijuana seeds in

clothing, automobile carpet or seats, or purse will signal marijuana involvement, as the seeds are not desirable for smoking and the user will try to sift them out before rolling a cigarette. There seems to be no limit to the kinds of paraphernalia used, so it is best to suspect and investigate anything that you feel needs further exploration.

NOTE: These are the obvious signs. There are also some physical signs, such as irregular menstrual periods in girls, which will not be noticed by school personnel.

Many efforts are being made by adults to provide "drug-free activities" for youth in hopes of demonstrating how to have fun without drugs/alcohol. Such activities are limited only by one's imagination, energy, and money. For example, parents, communities, or youth can sponsor:

1. Dances. These dances can be anytime during the summer months or holiday vacations.

2. Parties. Parties may be anytime or during a holiday and may include dancing, games, and races.

3. Workdays. Workdays are a worthwhile activity where youth take on a project to help the community, a family, or an organization in need. Anything with "hands-on experience" adds to the feeling of accomplishment, success, and self-worth.

4. Picnics.

5. Marathons. Bike-a-thons, mini-marathons, dance-a-thons, rock-a-thons, etc., for fun or for fund-raising.

6. Programs. Drug prevention programs which feature informed youth educating elementary-age children.

7. Youth clubs. Some communities have some success with such clubs, which typically are popular with elementary-age and some middle-school-age youth.

While these special events are fun and can be worthwhile, and do help keep youth in a safe environment for one day/night, there is a question whether the events play a major role in daily decisions about drugs/alcohol. Ultimately, it is the youth's choice and they are influenced by their peers. In Appendix C you will find some quotes from Dr. Robert L. Dupont that may be useful in parent education. If you choose to plan some parent-education sessions, these quotes may be helpful.

SECTION II

DEALING WITH THE PROBLEM

SCHOOL PERSONNEL, STUDENTS, PARENTS: WAYS TO DEAL WITH THE PROBLEM

Adolescents who kill themselves are at their ropes end. Adolescents who attempt to take their lives are characterized by a combination of longstanding problems and the impact of a recent precipitating event. In a recent study, 52 percent of precipitating events involved problems with parents, 30 percent involved problems with the opposite sex, 30 percent involved problems with school, 16 percent involved problems with brothers or sisters, and 15 percent involved problems with peers. Only five percent of the adolescents displayed psychotic symptoms such as disorientation, hallucinations, or thought disturbances. Further, school adjustment can be a precipitating factor--poor grades, truancy, and disciplinary problems at home or school. Because of these, it is recommended that schools consider implementing the following preventative measures:

A. School Personnel

1. In-service training on adolescent stress and how to help alleviate it in a school environment.

2. In-service training on the signs and symptoms of depression, substance abuse, sexual and physical abuse, and cues to suicide and other handicapping disorders. Emphasis should be placed on early identification of students at risk for problems. Referrals can be made to the crisis team (see below) and follow-up of referrals need to be done. Educators can become better observers of students' behaviors, more supportive of them, and can do less labeling of deviant behavior when it occurs in their classrooms.

3. Delegating the leadership for implementing a youth suicide prevention program at your school to a crisis intervention team selected from willing and qualified faculty. The team may consist of administrators, guidance counselors, school psychologists, nurse, social workers, or qualified teachers. Sometimes a supportive staff member like a secretary may be very effective on a crisis team, particularly if he or she has previously been trained (hot line).

   a. Selecting one member from the team (preferably by the team) to be the team's formal leader.

   b. Educating the team members about crisis intervention techniques. Crisis intervention is not psychotherapy but the restoration of students to their former emotional/behavioral states.

c. Emphasizing the importance of follow-up of referrals. A large number of students at risk never receive help, although help is desperately needed and often desired. A school policy needs to be made concerning students who refuse help or who are unable to receive needed help because of finances or parental cooperation.

4. Developing written policies and procedures for dealing with suicidal or depressed youths. A written policy on how to deal with a youth you suspect is abusing drugs is very helpful. Your policy can include:

When and how to refer to the crisis team

When and how to inform parents

When and how to inform administrators

When and how to counsel the youth

How to obtain an assessment for lethality (See Appendix B)

When and how to refer the youth to a mental health center

B. Students

1. Health curriculum for every student with the following suggested topics:

a. Positive self-esteem...an "I'm okay, you're okay" focus.

b. Effective interpersonal skills with peers and adults--getting into, maintaining, and terminating relationships. Learning social skills for dating and school activities can be beneficial.

c. A positive attitude toward loss, failure, and grief. Learning how to fail is as important as learning how to succeed.

d. Life skills--decision-making, values clarification, and problem-solving.

e. Stress management skills.

f. Substance abuse and its effects on the body.

2. Consider developing a peer support program (sometimes called peer counseling).

   a. Youth-staffed hotline

   b. Problem-solving with a peer. (Note: The National Youth Suicide Conference emphasized avoiding the phrase "peer counseling" as it can be misleading to students. It is recommended that peer counseling be called peer support and the focus should be supportive.

   c. Self-help group for maltreated teenagers and for those students needing a group experience, e.g., whose parents are going through divorce or who have suffered the death of a parent).

3. Developing a pamphlet for youth on guidelines for recognizing maltreatment and ways to help maltreated peers.

4. Developing a pamphlet for recognizing cues to suicide in their classmates.

C. Parent Training

1. A workshop can be held at your school to educate parents about youth's substance abuse, depression, and suicide. The workshop can focus on ways to prevent youth suicide and describe the relationship between substance abuse, depression, and suicide.

2. Educating parents on how to have effective communication with teenagers.

D. Indirect Education to Students and Faculty

1. Newspaper articles placed in school newspaper.

2. Presenting school plays or showing films on the problem of youth suicide and following up with resources for help.

In summary, an effective suicide prevention program at your school depends on the participation of students and parents in all aspects of the program. There are a multitude of excellent parental and student resources in every school. By involving parents and students in your program and delegating the responsibility to a trained crisis team, you have half the problem of youth suicide conquered. The other half involves community support. You will need to identify supportive services for youths in your area. If there are none, start some programs. Further, the maintenance of a collaborative relationship with community agencies involved in suicide prevention, education, and intervention is imperative.

They can serve as consultants, referral sources, and trainers of staff and students. By maintaining a collaborative relationship, follow-up of referrals can be better realized, particularly if you have a mental health liaison person at your school (leader of crisis team). A list of community mental health centers can be obtained from the Department of Mental Health (317/232-7913). Many physicians and counselors in private practice in your area may be willing to help with the problem of youth suicide. Invite them to help. A list of community resources dealing with the problems of youth could be developed in your community and distributed to the youths at your school.

INTERVENTION

What School Personnel Can Do

As school personnel you may be faced with crisis situations like students telling you they have been seriously contemplating suicide. When you are faced with that situation, you will need to know crisis intervention techniques. The first and most important principle in dealing with an adolescent crisis is TO GET HELP. Do not try to handle the problem alone! Before you make a decision regarding lethality or how to handle the situation, it is important to discuss the situation with someone else. Your school should identify members (crisis team) who are most capable in dealing with these sort of problems and someone from this team should be consulted.

The following crisis intervention strategies are reprinted here, with some slight modification, with permission from Iris Bolton, Director of Link Counseling Center, 218 Hilderbrand Avenue, Northeast, Atlanta, Georgia 30328, 404/256-9797. If you have any concerns or questions regarding these strategies, you may contact the State Board of Health, Division of Nursing, 317/633-8464, your local mental health center, "hot lines" in your area, or the Link Counseling Center (see above). These strategies should be used as guidelines and suggestions only, keeping in mind that each situation is unique and warrants its special crisis intervention technique.

Once you suspect that the adolescent is a potential suicide, the best approach is to confront the problem...you could ask, "Have you been thinking of harming yourself?" You will not put ideas in the youth's head and chances are he/she will answer you honestly. By using basic interviewing skills, you should try to answer the questions of who, what, when, and where. In suicide assessment, it is important to know "how." The "how" answers to the availability of means to commit suicide, and this is very important. For example, if a student tells you he has a gun at school, you would request additional help from your local sheriff or police department.

When you suspect that a teenager is suicidal, remember five things:

1. Discuss suicide openly and frankly.

2. Show interest and support. Communicate that you care and that you are trustworthy.

3. Get help (validate with someone you know who has some knowledge of suicidal behavior).

4. ASSESS LETHALITY: How will you harm yourself? A firm plan to killing oneself is serious, particularly if actions have been taken to carry out the plan.

IF YOU DETERMINE A STUDENT IS SUICIDAL:

5. DO NOT LEAVE THE STUDENT ALONE...UNDER NO CIRCUMSTANCES! YOU WILL NEED TO TAKE CONTROL OF THE SITUATION UNTIL YOU ARE CERTAIN THE STUDENT IS SAFE...THE STUDENT HAS BEEN TURNED OVER TO PARENTS, THE LAW, OR A MENTAL HEALTH PROFESSIONAL. THIS CANNOT BE IGNORED AND SHOULD BE ADHERED TO RIGIDLY.

The Issue of Confidentiality

You may be faced with a confidentiality dilemma. Youngsters often will share highly sensitive, personal matters with adults if they "promise not to tell anyone." It is easy and very tempting to enter into such an agreement; however, taking this approach is very dangerous. In these instances, teenagers want to tell you their concerns and want you to help. Their ambivalence is expressed by their desire to have you know and, at the same time, tie your hands to do anything about it. The best approach in this situation is to let the teenagers know that if what they are about to tell you could involve their harming either themselves or others, you would feel it your responsibility to seek help. The teenagers are asking for your help because there is some degree of trust between you and them. Acting in a responsible manner reinforces that trust.

Present options, options from which he or she can choose and still maintain dignity. For example:

1. "You can call this number (mental health crisis line in your area) while I'm here with you."

2. "I will call the crisis line and share my concern for you." or

3. "I will need to speak with your parents to see if we can work this through."

Crisis Intervention Guidelines

The Link Counseling Center recommends the following for dealing with someone who appears to be depressed, helpless, hopeless, or suicidal. These suggestions are here for you in emergency situations only. A trained member of the crisis team should be the one to deal with a suicidal crisis. It is emphasized that crisis intervention training is essential for working with a suicidal crisis.

Basic Strategy

1. Be calm and affirmative.

2. Connect with the youth and build a relationship, but know the ultimate decision to live or not to live is the adolescent's. Recognize that ambivalence characterizes the suicidal adolescent. They have as much will to live as they have will to die. You want to pull harder on the side that wants to live.

3. Listen and reflect back feelings to help the adolescent feel that someone has heard his pain.

4. Be nonjudgmental about values, beliefs, or behavior.

5. Acknowledge the reality of suicide as a choice but explore other alternatives.

6. Acknowledge the person's feelings of helplessness and discuss alternatives to suicide.

7. Instill hope and buy time.

8. Ultimately take care of yourself by prioritizing problems and planning action steps.

School personnel should use the following techniques <u>when appropriate</u>.

1. Express your appreciation for being with the person (e.g., "I want you to know that I appreciate your being with me right now.").

2. State your concern about his/her welfare (e.g., "I've been worried about you lately.").

3. Give nonjudgmental feedback about his/her behavior (e.g., "I've noticed that you aren't sleeping much; you're losing weight; you have withdrawn from people, groups, etc.; you're skipping school; you seem depressed and sad, etc.").

4. Confront the concern you have that he/she might be thinking of giving up on life (e.g., "I guess I wonder if you are thinking of giving up on life....or perhaps ending it all.").

5. Use yourself as an example, only if it is true for you (e.g., "When I've been really down and desperate, I've thought of giving up, too. It sounds like you might be feeling that way now.").

6. Normalize <u>thoughts</u> of suicide (e.g., "It's common for people to feel so helpless and hopeless sometimes that they think about ending their life. That doesn't mean that you have to act on it. Most of us think about that from time to time.").

7. Ask how he/she might go about ending his/her life (i.e., "If you ever were to really try to harm yourself, how would you do that? Have you thought about that?). If he/she knows how he/she would do it, the person is more at risk than if no plan is premeditated.

8. Ask if he/she has the "gun," "rope," "pills" (e.g., "Do you already have a gun?" or "How would you go about getting it?"). An available method to end one's life and the plans to do it are very serious.

9. Ask if he/she thinks the method chosen will really solve the problem (e.g., "Do you believe that will kill you?"). You are trying to determine how much he/she knows about the lethality of the means chosen. For example, if he/she has a gun and bullets, there is more risk than a person with 20 aspirin who is not sure if that is enough to cause death.

10. Ask what event precipitated the immediate crisis (e.g., "What happened that finally was the last straw for you?").

11. Reflect back to him/her the feelings you hear behind the response (e.g., "Sounds like you're feeling rejected... sad... alone... humiliated, etc., right now. You feel as if no one really cares for you").

12. Ask if he/she has ever felt this way before and, if so, what did he/she do then to feel better (e.g., "Have you ever felt this way before?" If the answer is yes, "What did you do then to take care of yourself and to feel better?"). You are exploring the person's own resources and strengths used in the past.

13. Ask, "On a scale of 0-10, if '0' is the worst you've ever felt and '10' is the best, where are you right now?"

14. Ask, "If you really did end your life, I wonder who you'd want to find you?" (Most suicides involve the relationship with one other person, at least as a precipitating factor, so you are trying to identify that person.) Explore that relationship and any sense of loss involved.

15. Ask about his/her support system--friends, family, etc. (e.g., "Who would you like to have with you now?" State, "It's important that I call in someone to be with you right now. I need to call in your folks."). State affirmatively that "you need to connect with those people who care about you and who can help you deal with this."

16. Share yourself and your resources (e.g., "I have a consultant who helps me when I'm stuck."--you are role-modeling here--"I need to touch base with that person in order to take care of me, to give me support when I feel hopeless.").

17. "I will call your ..... (parents, friend, relative, minister, etc.)."

18. Take charge if it is serious. You may say, "I will participate in your life, not in your death. For now we will do this....."

19. Do not leave the youth alone. Call a resource person (family, friend, etc.) in his/her presence so that he/she will not feel betrayed. Most people want you to take charge.

20. Wait for the resource person to come and share your concerns with the resource person in the presence of the suicidal person.

21. Make referral to: mental health center, psychologist, psychiatrist, hospital, or release the individual to the care of the parent, impressing upon them that the young person needs help--or accompany him/her to the hospital.

22. Know you have done all you can do to handle the crisis, and give yourself credit for being willing to risk with the teenager. Be sure to talk to a consultant about the situation to get support for yourself after the crisis is over.

Intervention adapted from the Link Counseling Center, Atlanta, GA.

It is important to remember that after a suicidal crisis you may feel very tired or "washed out." You should discuss the situation with someone you value and trust. In clinical situations, this is a time to go over what was learned. It can be a time for mutual sharing and support of one another.

Many times suicidal teenagers are manipulating and begging for attention. This can be a problem to a teacher. However, the student's need for attention ought to be addressed by a mental health professional, not you. Your role is to pay attention to ALL distress cues and not be concerned about manipulation...every hidden message that you suspect might be a cue, needs to be validated. Also, do not believe that a suicidal crisis is resolved after one session with you or anyone else. Be leery of potentially suicidal students who tell you that everything is okay now...they may have decided to kill themselves.

In Appendix B, you will find an assessment tool that may help you determine students at risk in classrooms. This observational tool can be distributed to all faculty.

SUGGESTED POLICY
FOR THE CRISIS INTERVENTION TEAM
FOR DEALING WITH REFERRALS RELATING TO SUICIDE

SUGGESTED POLICY:

If any Board of Education employee determines that a student is planning suicide, the following procedures will apply:

1. Report any potential threat or suicidal student to a member of the crisis team (psychologist, guidance counselor, nurse, social worker/substance abuse counselor and, always, the school administrator).

2. A member of the crisis team (psychologist, guidance counselor, nurse, social worker, or administrator), in collaboration with another team member, shall be responsible for determining the seriousness of the threat. In the case of a life-threatening situation, the student and the staff members involved must understand that the issue of confidentiality shall no longer apply.

   a. Question the student about any feelings of hopelessness and the length of time of such feelings.

   b. Question the student about any thoughts about killing himself/herself and discuss the persistency and strength of the thoughts.

   c. Question the student to determine whether any plans have been made, the details of the plan, and whether any preliminary actions have been taken. Determine lethality for suicide. (on the following page)

DO NOT LET THE STUDENT OUT OF YOUR SIGHT!!!

3. The parent must be notified immediately!!

4. The student may only be released to a parent/guardian, law enforcement official, or emergency medical staff.

5. Make the parent aware of sources of help. It is useful to have a resource guide to give parents or guardians. Encourage them to obtain help.

6. Follow up to be sure that some contact has been made for help. It is helpful to have a follow-up form made to send where referrals are made. Obtain permission from the parent or guardian for the release of information, as many agencies cannot discuss problems with you without parental/guardian permission.

*LETHALITY ASSESSMENT

THESE SIGNS, SEEN EVEN ONLY ONCE, REPRESENT A VERY HIGH LETHALITY

Giving away of personal possessions	YES	NO
Discussion and/or making of suicide plans	YES	NO
Discussion and/or gathering of suicide methods	YES	NO
Previous suicide attempts or gestures	YES	NO
Scratching, marking body, other self-destruction	YES	NO
Death themes throughout spoken, written, and art works	YES	NO
Expression of hopelessness, helplessness, and anger at self and the world	YES	NO
Use of dark, heavy, slashing lines, unconnected bodies in art work and doodling	YES	NO
Statements that family and friends would not miss them	YES	NO
Recent loss through death	YES	NO
Recent loss through suicide	YES	NO
Sudden positive behavior change following a period of depression	YES	NO
Anniversary of a significant loss	YES	NO

*The tool on lethality assessment has been reprinted here through the courtesy of the Suicide Prevention Center, Dayton, Ohio.

SUGGESTED GUIDELINES AFTER A SUICIDE OR SUDDEN ADOLESCENT DEATH

The following guidelines have been compiled from several school districts' responses to student suicides. Recognizing that each school is unique, these guidelines are given to you as suggested procedures and they can serve as a springboard for discussion and planning in your own school.

Credit to Dr. Joseph Solanto for his article, "The Days After: A School's Response in the Aftermath of Sudden Adolescent Death" in Teenage Suicide: Prevention, Intervention Response. In discussing the problem of suicide or sudden adolescent death, Doctor Solanto stated that reverberations from the loss are felt for at least two years following a traumatic death. Frequently, aftereffects are felt as a pervasive sense of malaise among the students and school staff. He states that teachers are devastated well into the next school year, and there may be a change in attitude towards teaching...a loss of joy can occur towards their work. They may increase their emotional distance from students. Students tend to be fearful of getting close to one another, fearing the loss of another classmate or friend. The need to cope adaptively is necessary. Suggestions printed here have worked in other schools.

DAY OF SUICIDE/DEATH

Faculty

1. School principal initiates "chain call" to all faculty and support staff informing them of the suicide and requesting their arrival at school 30 minutes earlier to attend a special faculty meeting.

2. Telephone conferences with crisis team members are held to plan tentative activities for the next day (day after a suicide).

FIRST DAY AFTER A SUICIDE/DEATH

1. School principal meets with crisis team 30 minutes before meeting with faculty to plan the aftermath of the suicide.

2. Principal reviews the facts of the case with all the faculty and support staff to dispel rumors, to discuss the plan of the day, and to allow for faculty members to express their feelings. Faculty/staff are encouraged to lend support to one another.

3. A member of the school crisis team or a mental health center worker gives the faculty all the facts of the death. A member of the crisis team describes some of the feelings the students may be experiencing following the death of a classmate...disbelief, anger, denial, sadness, loss. Suggestions are reviewed on ways to encourage the expression of grief in their classes and a handout on "Response of Staff after a Youth Suicide" can be distributed. (See page 37)

4. A crisis center is established in the guidance office. Additional pupil personnel staff from other buildings and from neighboring school districts may be called in to assist with the crisis. Staff from your local mental health center can be helpful. A member of the crisis team makes phone calls to parents of students who are particularly upset or may be at risk. The crisis team member can explain the students' reactions to the death and the team member can make appropriate suggestions to parents on ways to manage their children. It may be necessary for parents to come to school and take the youth home for the day or to receive immediate professional help. Resources for prfessional help are made available.

5. A call is made by the principal or designee to the local mental health center (if not done sooner) to notify them of the problem of the youth suicide or sudden adolescent death and arrangements are made to elicit help from them.

   -- When outside consultants are called upon, they can be useful because they are generally not emotionally involved with the case and can provide objective support and direction. Some of the services they provide are:

      Individual counseling for students.

      Speaking at a general faculty meeting on the issue of adolescent suicide; identification, prevention, response, and help with some of the concerns generated in staff or in students.

      Conducting evening informational meetings for all concerned community members.

6. "Peer Facilitators" (if your school has a peer support program) are assembled to work through their feelings, and the crisis team members can offer them some guidelines for helping their troubled friends.

7. School staff are assembled for one hour (minimum) at the end of the school day. The principal conducts the meeting and does the following:

   a. Allows for the expression of feeling and mutual support.

   b. Reviews the events of the day.

   c. Reviews the characteristics of high-risk students (those who seem especially upset or depressed or show other signs of not coping well) and compiles a confidential list of staff observations of distressed students' reactions during the day.

   d. Announce the wake and funeral arrangements and encourage staff to attend in order to provide support to students and their families.

SECOND DAY AFTER A SUICIDE/DEATH

1. Announce an open meeting for concerned parents. This can be an evening meeting.

2. Meet at the end of the day to discuss staff concerns regarding events of day.

3. Crisis team members and clinical staff continue crisis intervention, answer phone calls of anxious parents, and meet with concerned staff.

4. Principal writes letters to all parents of "high-risk" students reminding them to seek professional evaluation.

5. Outside consultant and school staff conduct an evening meeting of concerned parents. The consultants, making use of their "expert" status, urge the families of those students who are not coping well to pursue evaluations at one of the public or private mental health agencies listed in their area. Crisis team members and clinical staff are available to privately answer parents' specific concerns about why some children were identified as "at risk" or any other concerns parents may be having. Clinical staff meet for half an hour following parent meetings to discuss meeting.

THIRD DAY AFTER A SUICIDE/DEATH

1. "School/Community Steering Committee" is formed and generates plans for a meeting involving interested community leaders to discuss a community-wide response to the needs of the youth of the town or area. Take into consideration leisure time activities, alternatives to school suspension, incarcerated and minority youths' concerns, and runaways.

2. "Front-line" staff who have been dealing directly with the crisis meet with a consultant for the expression of feelings and mutual support. (This is a very necessary ingredient, as "burnout" can be a problem with crisis situations.) Also, former losses of "front-line" staff may come to current awareness. A mental health consultant is very useful to prevent staff burnout.

Some Additional Suggestions:

These suggestions should be addressed soon after the youth's death has been announced.

-- Assign one school authority to interact with the media. A fine line needs to be walked to ensure honest reporting of the student's involvement in the school. For further discussion on how to work with the media, it is discussed later in this manual.

-- The principal, along with a selected member from the crisis team, should visit the victim's family at home. In addition to the expressions of sympathy and support, plans for a memorial service at school might be made. Also, the student's personal belongings from lockers, etc., can be returned to the family at this visit or plans can be made to return the belongings to the family. Advice can be given with regard to contacts by the media.

-- A memorial service during the school day should be conducted. This is a voluntary service for students, family and faculty who wish to attend. The service will not glamorize the suicidal act and references can be made to the act as an unwise decision or an error in judgement. Dr. Solanto suggests that the service should serve as the institutional "signal" that the official period of mourning is over. Future memorials, such as trees planted in memory of the student, plaques, etc., may be permitted. The work is not over at this point, but can be an ongoing process of prevention of youth suicide. You will need to make a decision at your school when "business must go on as usual."

Adapted from: Solanto, Joseph. "The Days After: A School's Response in the Aftermath of Sudden Adolescent Death" in Teenage Suicide: Prevention, Intervention, Response. Cosad and Four Winds Hospital, c1984, pg. 10-12. Contact Doctor Solanto at Rt. 22, Trico Building, Croton Falls, New York, 10519, 914/221-6867.

RESPONSE OF STAFF AFTER A YOUTH SUICIDE

-- Staff are encouraged to allow for the expression of grief in their classes in whatever way and to whatever extent they are comfortable. (See ahead for recognizing students at risk during classroom discussion). The guiding principle is to return to the normal routine within each class and within the school as soon as possible.

-- The teachers are asked to dispel rumors whenever and wherever possible and to discourage any "glorification" of the death. For example, if a student is heard to say, "I wouldn't have the guts to kill myself!", the teacher can respond, "Suicide is not a brave act! It is far more courageous to go on living and to face your problems each day as you and I do."

-- Review the known facts and dispel rumors.

-- Help students separate reality from fantasy and de-mythologize the suicide act.

-- Inform them of the crisis center at the school and availability of support from it. Inform them of community resources for mental health. It is helpful to distribute a written list of names, phone numbers, and addresses of resources.

-- Encourage students to express their reactions in whatever way is appropriate for them. (All responses are acceptable, from severe upset to no reaction whatsoever.) See "Guidelines for Recognizing Students Needing Help Following A Youth Suicide."

-- Discuss possible guilt or feelings of responsibility that students may be having.

-- Ask students to be supportive of one another and to escort any friend who is upset to a member of the crisis team or to the crisis center.

-- Reassure students that any adult in the building is available to help in an emergency or is willing to listen. Members of the crisis team need to be consulted about any problems.

-- Encourage students to discuss their feelings with their parents.

Adapted from: Solanto, J., 1984, pg. 8-9

GUIDELINES FOR RECOGNIZING STUDENTS AT RISK
FOLLOWING A YOUTH SUICIDE

A problem with classroom discussions of a recent suicide centers around bringing closure to the discussion. Bringing closure means that feelings have been ventilated and students have reached some degree of understanding and acceptance and have pulled themselves together in order to "return to work." Not all students will have accomplished this within the time frame of a school period. The issue then becomes identifying students who need to be referred to the crisis center for further help. Wide variations in how people deal with feelings will make referral problematic. The following general considerations should be evaluated in order to determine a need for a mental health referral.

1. It should be expected that some students will cry. Students who have been unable to control crying by the end of class are obvious choices for referral.

2. At the other end of the continuum will be students who are showing no visible emotion. "Expected reaction" is a function of the degree of closeness between the victim and the student. In the cases where it is known that a student was close to the victim yet is showing no reaction, a referral is recommended. This category is the most difficult to assess. Many students who were not close to the victim will feel very little. Also, a numb, dumbfounded response is a common response to tragedy. Finding the emotionally overcontrolled among this group will depend primarily on a teacher's knowledge of social relationships.

3. Anger as well as grief is a normal response to suicide. However, if a classroom is responding predominantly by grieving, then an angry student may feel compelled to remain silent. This student would be a good candidate for the crisis center.

WORKING WITH THE MEDIA

The following suggestions on working with the media are copied with permission from J. Ring, B.S., "Teenage Suicide: Prevention, Intervention Response," in manual from Cosad and Four Winds Hospital, c1984, p. 13-16.

I've walked both sides of the communications gap during a 20-year career in the communications business. As a newspaper and radio reporter, I went after the facts. As the public relations spokesman for the public and political and private entities, I dispensed information within the context of my employer's best interests. The contrast in those roles offers the perspective upon which my recommendations are based. Several years as a secondary education classroom teacher bring an understanding of the unique problems and dilemmas of the schools in working with media.

Media policy varies from one school district to another. The primary spokesman may be the superintendent, a public information officer, a central staff member, or even the building principals. Information may be channeled exclusively through one person on a regular basis, or there may be considerable latitude regarding talking to reporters depending upon the story or issue.

Given these differences in approach, the following suggestions are intended as guidelines to follow, no matter who is doing the talking.

In order to work constructively with the media, we first need to look at some of the stereotypical biases which affect our thinking and, thus, our actions and attitude toward reporters. Journalists are plagued by a frequently held notion that they are all muckrakers, sensationalists, unscrupulous, insensitive, will spare nothing to "get the story," and can't be trusted. Of course, that is no more the universal case than it is for other professionals who are labeled with similar negative adjectives. It's a matter of some "bad apples" spoiling the bushel.

Even though personal experience may have run to the contrary on occasion, the fact is that the majority of journalists work hard under deadline pressures, try to be accurate, have a job to do, a boss to answer to, and want to be treated as decent human beings. If you accept that and are willing to believe it, you've taken the first constructive step in working with media through a school crisis.

The conflicts which can arise between reporters and the schools stem less from inherent differences than from a perceived disparity in goals. There is a common element--both have a job to accomplish. The reporter has a story to file. The school needs to carry on business with as much normalcy as possible. With some advance thinking and planning, both can be accomplished. How?

Deal up-front with reporters.

A good communication system with local media should already have been established. If you have that as a basis, working through a crisis situation is not nearly so difficult. If your present relationship with local media is wanting or needs improvement, take the first step. Invite them to the school for a special function; offer a good feature story; brief them on upcoming events; be accessible; return telephone calls promptly. In other words, be up-front, forthright, and honest, and you'll earn the respect, and even friendship, of reporters whom you can trust when crisis comes. They won't try to mess you up in a crisis if you have been a decent sort right along.

Don't try to "stonewall" the media.

Attempting to stop reporters from doing their job is how that's perceived. Nothing is so infuriating to the media, or so futile for the "stonewaller." Remember, you are not the sole source of information. Police reports are public documents; newsrooms have scanners; police checks are a twice-daily routine in most newsrooms; reporters have personal sources. Decide what is appropriate for the school or district to say and say it. Prepare and issue a statement. Express the sorrow of the faculty and student body, explain what is being done in the school to deal with the reaction to a suicide, make positive comments about the deceased student.

Another appropriate method is to hold a briefing for the media. Issue your statement, answer any questions which do not violate confidentiality, explain your ground rules for coverage of the story. If you are asked a question which is clearly inappropriate, don't get angry. I've often responded to such situations by saying, "Come on, you know I can't answer that." Most reporters will understand; some just ask to see how far they can get. In terms of ground rules, point out that you can't have the students even more disrupted by having reporters on the school grounds. Ask them to stay off, as it's private property. Explain that you don't want a confrontation with them; but if they push the issue, you'll have them removed. You can be clear without being nasty. Just spend some time explaining your position and they'll cooperate if you're reasonable.

If you get a surprise visit from a television crew or unfamiliar media, invite them into your office. Explain the ground rules about disrupting the school routine. Ask what you can do to help them. Consider anything which seems feasible; don't say "no" without thinking about it. There are many positive uses of the media, particularly in getting a prevention message across. Remember that your lack of cooperation isn't going to have any impact on whether or not the story is covered. Where you can impact is how it's covered, e.g., in a sensational or factual manner. If you give the media something sound to talk about, they are much less likely to be sensational. They aren't going away just because you won't talk.

And, by the way, I've talked to a number of reporters who are very sensitive about excessive media coverage of teenage suicide. They don't want to exacerbate the problem; but if that's their story assignment, they don't really have a choice. The faster they cover it, the faster they'll move on to the next story.

Identify a single information source.

Do not wait for a crisis. Do it now. Clearly, that decision rests with the chief school district administrator. Whether it is the administrator, a public information or public relations specialist, or the building principal is less important than having one consistent source where a reporter can turn for information. Obviously, the person selected should have good human relations skills, feel comfortable with the media, and be readily accessible. They need to know all the facts, determine what is appropriate to state, and return media telephone calls promptly. The media need to know exactly who to contact, so call the local media and tell them.

Advise school personnel of the media procedure.

Make certain that the faculty knows the name and phone number of the media contact person. If they are asked for official comments, they can refer the reporter to that person. On the other hand, if they are asked for personal comments about the student, it should be left to their good judgment what to say. There is no point in telling staff not to talk to reporters; trust their professionalism. Besides, what's really wrong with a teacher saying something positive about the deceased student? What would be inappropriate is any comment about the mental/emotional/psychological aspects or history. That information is contained in the confidential records in any event, and these should be removed to a secure place.

Advise students of the district's media procedure.

Tell students how the district plans to disseminate information to the media. Explain that reporters may ask them questions. Suggest that they not make any comment they wouldn't want said about themselves. If you appeal to their sensitivity, they are much more likely to use good judgment. It is useless to try to stop anyone from talking to reporters who want to, off school grounds. However, students need to understand that they don't have to talk to reporters and should feel free to say "no" if that's their inclination.

Consult with the deceased student's family.

Explain the parameters which the school district has established. Assure them that confidential information is being protected. State the exact plan for dealing with media matters so that there is no possibility of misunderstanding the school's position. Offer to help them in any way in dealing with media, even down to issuing a statement through the school.

Consider the future.

Once the immediate crisis has abated, consider the possibility that you may be contacted in the future on the subject of teenage suicide or asked for follow-up information about education or prevention programs in the schools. Ascertain the thrust of the coverage. Determine the seriousness of the approach. School districts show themselves as responsible and caring if they have instituted various kinds of prevention programs, made curriculum changes, established peer-counseling groups, or taken some other step to deal with teenage suicide. The public should know about it.

We all talk about the partnership between educators, parents, and mental health professionals which is needed to effectively combat this terrible reality. The media can be a constructive part of that partnership as community educators, if you learn how to work with them effectively.

Reprinted with permission from Jackaline Ring in Teenage Suicide: Prevention, Intervention, Response. Cosads and Four Winds Hospital. c1984, pg. 13-16.

GRIEF

When a loved one is lost through suicide, the emotional impact is often devastating. The grief process is often intensified by the guilt and stigmatization of the death being a suicide. School staff will have to deal with people in the beginning stages of grief, and you may feel the impact of their emotions being directed at you. School personnel are often overwhelmed with these emotions. Understanding of what's happening can be helpful.

In the first few hours, days, or weeks, and recurring off and on for a long time, the survivors are likely to feel shock. They may feel disbelief and numbness and behave as if nothing has happened or in a mechanical manner. They may keep repeating, "I just can't believe it."

In the second stage, catharsis, the shock will begin to wear off, and the beginning of a realization of what has happened and what it implies will occur. Crying is as common as the initial feelings of guilt and anger. Anger is often overwhelming, and directed at everyone, especially the people who have told them of the death. It is important to remember not to take it personally, as it is not meant personally.

In later stages the depression, preoccupation with the loss, and intense feelings of guilt and anger must be worked through until the person finally comes to terms with the loss. Some people never come to terms with the loss.

The amount of guilt that a survivor of suicide feels is far greater than the amount felt by the survivors of other deaths. They may continually ask themselves, "What did I do wrong?" "Why wasn't I there?" The emphasis on "What I did" distinguishes it from other types of death. This is especially true of parents who survive the suicide of a child.

In addition, the anger felt by suicide survivors may be immense and directed at everyone. They may be angry at school personnel whom they think did not do enough, at police who should have gotten there more quickly, or at the people who told them of the death or the means of death. It is not anger directed at anyone personally, but at everyone. Time, a helping hand, and a nonjudgmental attitude are helpful to the bereaved. Pathological grief is identified by the intensity and duration of the grief. If the bereaved is unable to carry out the usual living activities after a period of time, outside help may be needed. In order to express the depth of the loss of a child, a mother who recently lost her daughter through suicide has written of her experiences. It has been printed in the introduction. It is a touching essay, and it is our hope that you will understand the immense loss and grief felt by parents who lose their child through suicide. On pages 46,47 in this manual, you will find a list of Indiana Chapters of Compassionate Friends, and a directory of Survivor's Support Groups, United States.

J. Heller from the Suicide Prevention Center, Dayton, Ohio, and adapted for this manual.

EDGEWOOD HIGH SCHOOL MODEL FOR SUICIDE INTERVENTION
FOLLOWING TWO SUICIDES IN 1985

This model was developed to try to break the cycle of multiple suicide after two freshman students had committed suicide within a three-week period of time.

The program involves mental health professionals, family counselors, community ministers, parents, school counselors, teachers, administrators, and students.

Large Group Presentations

An assembly program lasting approximately forty minutes was presented to freshman and sophomores. The assistant principal delivered a short memorial to those who had committed suicide and asked students to consider what their last memories of the suicide victims were. It was also stressed that many students were having a difficult time coping with the grief and discussion on what some of those feelings probably were.

The parent of the first victim, a girl, volunteered to come to speak to the students about what it was like to come home and find your daughter dead. She also spoke about all of the ugly rumors that started about her daughter shortly after her burial. She related how it is at home for the rest of the family.

A second assembly was held for juniors and seniors at which time a very similar format was used.

We felt that two assemblies were better than one. Some of the students in the younger group were more involved with the victims than most of the older students.

Small Group Presentations

Following the large group presentation, students were broken into groups of approximately twenty to twenty-five. A mental health professional along with a teacher presided over these groups.

In the groups, students were encouraged to express their feelings about what had happened and to ask questions about their feelings. They were also given a card to write anything they wanted to write about the situation or to ask a question privately. They were also encouraged to request a conference with anyone they would like to talk to if they were having difficulty coping with the deaths of their friends. They could request a minister, school counselor, mental health or family service counselor, teacher, parent, or friend. The cards were presented to the mental health representative who stood at the door to collect them and who the students were told would be the only person to see their comments or requests.

Individual Counseling

Four hundred students responded in some manner on the cards. Some made comments about the program, their own feelings, and asked questions; 32 requested individual counseling, and eight made comments that alerted mental health people to their need for counseling. Four cards contained negative comments about the program.

Family services made staff available for two weeks to counsel the students who had requested help and those that they identified as possibly wanting help. Some students and parents were asked to come for family counseling after these initial sessions at school.

Parent Meeting

Parents were encouraged through the media to come to a presentation at the high school to hear mental health people speak on things they should be able to recognize as possible signs of depression and potential suicide in their children.

Peer Counseling and Peer Support Groups

We hope to implement a peer counseling program for our students next year based on the Varenhorst Model in California. It will be an ongoing program to meet the needs of our students.

Parent Support Group

We are trying to organize a parent group to talk about common problems they have in raising their teens and ways that they have successfully solved some of those problems.

For more information regarding this format, contact Dixie Kline, Consultation/Education Services, c/o South Central Mental Health Center, 645 South Rogers, Bloomington, Indiana 47401.

INDIANA CHAPTERS OF COMPASSIONATE FRIENDS

Anderson:	Anderson Chapter R.R. 7, Box 150, Anderson, IN 46032 Linda Metcalfe, 317/378-7271
Bloomington	Monroe County Chapter P.O. Box 1884 Bloomington, IN 47402 Judy Leonard 812/339-3587 Linda Trader 812/829-4514 Dixie Kline 812/339-1691
Carmel/Indianapolis:	Carmel/Indianapolis Chapter 1049 High Court, Carmel, IN 46032 James and Andrea Gambill, 317/846-9429 or 6039 West 29th Place, Indianapolis, IN 46224 Mary Lee Long, 317/298-4325
Elkhart:	The Michigan Area Chapter 3538 Wood Boulevard, Elkhart, IN 46516 Howard and Jean Thursby, 219/295-8381
Evansville:	Evansville Chapter 2065 Bayard Park Drive, Evansville, IN 47714 Jack and Midge Barns, 812/476-8175
Fort Wayne:	Fort Wayne Chapter 5234 Bluffside Avenue, Fort Wayne, IN 46815 Harry and Marge Smith, 219/485-4528
Greenwood:	Greenwood Chapter 3080 Grace Street, Greenwood, IN 46142 Garaldean Bailey, 317/881-9066
Kendallville:	Kendallville Chapter R.R. 2, Box 5, Wolcottville, IN 46795 Olive Oesch, 219/854-2942
LaPorte:	LaPorte County Chapter 211 Woodward Street, LaPorte, IN 46350 Mary Aftowski, 219/362-2835
Logansport:	Logansport Chapter 1826 North Street, Logansport, IN 46947 Barbara Dingeldein, 219/753-8714
Moores Hill:	Dearborn County Chapter R.R. 2, Box 75L, Moores Hill, IN 47032 Joe and Carol Kovach, 812/744-3501

INDIANA CHAPTERS OF COMPASSIONATE FRIENDS

(Continued)

South Bend:	St. Joseph County Chapter 16733 Jackson Boulevard, South Bend, IN 46383 Denny and Jan Horral, 219/255-8249
Valparaiso:	Valparaiso Chapter 102 Appletree Lane, Valparaiso, IN 46383 Faye Merritt, 219/763-1629
Vincennes:	Vincennes Chapter R.R. 1, P.O. Box 86, Decker, IN 47524 Billie Mayal, 812/744-3501
Wabash:	Wabash Area Chapter P.O. Box 64, Roann, IN 46974 Laura Shaw, 317/833-2304
Gary:	Rosemary Hill, 219/944-6686
Rest of Lake County:	Chris McDonald, 219/464-1516

NATIONAL DIRECTORY OF SURVIVOR'S SUPPORT GROUPS, 1983-84

Alabama

Birmingham, AL 35222
Steve Neal/Kitty Douglas
3600 8th Avenue, S.E. 112
205/322-0445

Mobile, AL 36609
Robert L. Godwin, Jr.
260 Jackson Drive
205/342-0616 (Home)
205/473-3525 (Office)

California

Los Angeles, CA 90002
Life After Suicide
Janet Belland
1041 South Menlo Avenue
213/386-5111

San Anselmo, CA 94960
Marin County Grief
Counseling Program
Box 792
415/454-4566

San Diego, CA 92103
Survivors of Suicide
Ron Lofgren, M.S.W.
3425 Fifth Avenue
619/295-7661

San Francisco, CA 94118
Self-Help Grief Group for
Survivors of Suicide Victims
Robin Raber-Luna/Dorothy Stapp
3940 Geary Boulevard
415/752-4860

Colorado

Colorado Springs, CO 80909
Heartbeat
La Rita Archibald
2015 Divon
303/596-2575

Delaware

Wilmington, DE 19801
Reverend Marlene Walters
Grace United Methodist Church
4th and West Streets
302/655-8847

Wilmington, DE 19802
Reverend Paul Bauer
Penisula - McCabe United Methodist
22nd Street and Baynard Boulevard
302/655-8847
302/652-0326

Florida

Tampa, FL 33610
Survivors of Suicide
Mary Agresti
2214 East Henry Avenue
813/238-8821

Orlando, FL 32803
Survivors of Suicide
Marge Greenbaum/Jan Walker
112 Pasadena Place
305/425-2624

Georgia

Atlanta, GA 30328
Survivors of Suicide
Iris Bolton, Link Counseling
Center
218 Hilderbrand Avenue
404/256-9797

Illinois

Chicago, IL 60606
L.O.S.S.
Reverend Charles T. Rubey,
Catholic Charities
126 North Desplaines Street
312/236-5172

Geneseo, IL 61254
Transition
Lori Forsyth
552 East Pearl Street
309/944-4435

West Dundee, IL 60118
Survivors of Suicide
Stephanie Weber-Slepicka
512 Liberty Street
312/426-8611

Belleville, IL 62223-2096
Survivors of Suicide
Marcie Ehret
7623 (Rear) West Main
618/397-0968

Indiana

Indianapolis, IN 46201
Survivors of Suicide
Pat Walsh/Jim Gaynor
1433 North Grant Avenue
317/359-5825

South Bend, IN 46615
Survivors of Suicide
Shar Joyce
706 South Ironwood, Room 11
219/288-8126

Mooresville, IN 46158
Survivors of Suicide
Reverend Harold R. Walker
Indiana and Harrison Streets
317/831-3376

Iowa

Iowa City, IA 52240
Ray of Hope
Elnora "Betsy" Ross
1518 Derwen Drive
319/351-0330

Waterloo, IA 50701
Suicide Grief Support Group
Mr. Keith Stokes
1759 Pinehurst Lane
319/234-1724 (Office)
319/233-5538 (Home)

Kansas

Kansas City, KA 66105
Survivors of Suicide
Jan Olds
816/561-6675

Louisiana

Baton Rouge, LA 70898
Suicide Survivors Support Group
Celia Maith
P.O. Box 80738
504/924-1595

Metaire, LA 70005
Survivors of Suicide
Glen Rae Hennessey
316 West William David Parkway
504/529-3415 (Crisis Center)
504/834-7589 (Home)

Maryland

Silver Springs, MD 20902
Seasons
Ellen Zinner
10502 Huntley Place
301/649-5399 (Home)
301/321-2927 (School)

Baltimore, MD
Seasons
Marilyn Mossman
301/252-7616

Rockville, MD 20853
Seasons (Bethesda Chapter)
Coryne Melton
13907 Vista Drive
301/460-4677

Massachusetts

Boston, MA 02199
The Samaritans
802 Boylston Street
617/536-2460

Lawrence, MA 01840
Safe Place
Sally Gasper
35 Jackson Street
617/688-6607

Michigan

Grand Rapids, MI 49508
Survivors of Suicide
Ethel Bucek/Lois Stuery
1777 Pineknoll, S.E.
616/455-0372

Detroit, MI 48226
Survivors of Suicide
220 Bagley, Suite 626
313/224-7000

Minnesota

Burnsville, MN 55337
Survivor of Suicide Support Group
Linda Mahoney
12931 Portland Avenue, S.

St. Paul, MN 55108
Survivor of Suicide Support Group
Verlyn Smith, Campus Ministry
1407 North Cleveland

Shorewood, MN 55331
Survivor of Suicide Support Group
28125 Woodside Road

Edina, MN 55436
Survivors of Suicide
Adina Wrobleski
5124 Grove Street
612/929-6448

Missouri

Carl Junction, MO 64834
Ray of Hope, Inc.
SuAn McReynolds
421 Timber Lane
417/782-0219 (Home)
417/624-8100 (Office)

Crestwood, MO 63126
Survivors After Suicide (S.A.S.)
Jacqueline Stock
1536 Sappington
314/961-0608

Joplin, MO 64801
Joplin Ray of Hope, Inc.
Roger Paige, Ph.D.
Missouri Southern State College
417/624-5194 (Home)
417/782-1443 (Office)

New York

Albany, NY 12203
The Samaritans
Karen Wasby
P. O. Box 3822, Stuyvesant Plaza
518/482-0799

New York, NY 10023
Friends and Relatives of
Suicide Victims
Delores Miller
155 West 68th Street, #722
212/799-8547

New Jersey

Flemington, NJ 08822
Survivors of Suicide - Hunterdon County
Diane Schulman
R.D. #6, Box 49A
201/788-1372

Hackensack, NJ 07601
Survivors of Suicide
Jo Pesaresi
268 Euclid Avenue
201/342-6887

Mountain Lakes, NJ 07046
Survivors
Donna D. Bettes, R.N., M.N.
19 Raynold Road
201/788-1372

North Dakota

Fargo, ND 58103
Suicide Bereavement Support Group
The Nativity Catholic Church
Sister Jane Walker
1825 South 11th Street
701/232-6471

Ohio

Akron, OH 44313
Survivors
Sharon Aschelnan, Support
1361 West Market Street
216/864-7743

Cleveland, OH 44135
Survivors, Inc.
Johnnie Marks
216/932-4554

Dayton, OH 45406
Survivors of Suicide
Wanda Y. Johnson
Suicide Prevention Center, Inc.
184 Salem Avenue
513/223-9096

Oxford, OH 45056
Cincinnati Survivors After Suicide
Cynthia Kelley/Theresa Thiemann
522 South College
513/523-8646

Springfield, OH 45505
Survivors of Suicide
Bonnie Roush/Jovetta Krietz
2115 Lexington Avenue/or
Wittenberg University
513/322-9696 or 513/327-7414

Rhode Island

Providence, RI 02903
The Samaritans (The Safe Place)
Carolyn Benedict Drew
33 Chestnut Street
401/272-4243

Tennessee

Memphis, TN 38104
Survivors of Suicide
Mary Puckett
P.O. Box 40068
901/276-1111

Texas

Dallas, TX 75204
Dallas Suicide and Crisis Center
Survivors of Suicide Support Group
2910 Swiss Avenue
214/828-1000

Fort Worth, TX 76133
Survivors of Suicide
Patty and Larry Grubb
First United Methodist Church
P.O. Box 16961
817/924-9201

Utah

Salt Lake City, UT
Seasons: Suicide Bereavement, Inc.
Christina Byrd
4777 Naniloa Drive
801/272-0438

Virginia

Alexandria, VA 22306
Suicide Survivor Support Group
Helen Fitzgerald
8110 Holland Road
703/360-6910

Wisconsin

Milwaukee, WI 53222
Survivors of Suicide
Sharry Schaefer
3251 North 78th Street
414/442-4638

Milwaukee, WI 53210
Life-Line
Grace Hicken
2869 North 58th Street
414/445-6522

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APPENDIX A
INDIANA ADOLESCENT SUICIDE FACT SHEET, 1984

The following information was gathered from Indiana Vital Statistics, Division of Public Health Statistics; and from the Office of Health Planning and Policy Development.

The data have been broken down by age categories of 0-14, 15-24, 25-64, and 65+. As a result, data on the 13-19 year age group is not readily available, and this makes it difficult to project an accurate picture of numbers of adolescent suicides.

It is also important to note that the statistics represent only reported suicides and not unreported attempts.

1. The suicide rates in the 15-24 year age group have fluctuated between 1977 and 1984 with a slight increase (rate 1.7 per 100,000) for 1984.

2. A total of 654 suicides in all age groups was reported in 1984 for a rate of 11.9 per 100,000. The following table shows the number of suicides and rates by age group:

AGE	NUMBER	RATE PER 100,000
0-14	4	0.3
15-24	105	10.7
25-64	412	15.6
65+	113	21.5
TOTAL	654	11.9 (up 1.7 from 1983)

3. Suicide is, for the most part, a problem of the white male population. Of the 654 total suicides, 499 (20.5 rate) were white male, 135 (5.2 rate) white female, 16 (6.9 rate) nonwhite male, and 4 (1.6 rate) for nonwhite females.

4. Of the 105 suicides between ages 15 and 24, 88 (18.1 rate) were white male, 18 (4.1 rate) white female, 5 (10.5 rate) nonwhite male, and 2 (3.9 rate) were nonwhite females.

5. The 4 (0.7 rate) documented suicides for ages 0-14 were within the white male category.

---

*All rates are for 100,000 people.

6. The male rate was almost four times the rate for females. (Total male suicide rate is 19.3/100,000, and total female rate is 4.9 per 100,000.)

7. In 1984, suicide was the second leading cause of death for males and fourth for females in the 15-24 age group. (See table below.)

Five Leading Causes of Death
for Ages 15-24

	MALE	FEMALE
1.	Accidents	Accidents
2.	Suicide	Homicide
3.	Homicide	Cancer
4.	Cancer	Suicide
5.	Heart Disease	Heart Disease

8. Although suicide rates between 1950 and 1984 for the 15-24 age group have tripled, the rates in Indiana since the early 70's have remained relatively stable.

9. In comparing the 1960-1978 Indiana rates to United States rates, Indiana suicides (15-24 age group) were continually below that of the nation. The national suicide rate is 12.3 for 1980, and approximately 8.4 to 13 percent of "normal" high school students have made at least one suicide attempt. This means that between 1.6 and 2.4 million adolescents are likely to have made one or more suicide attempts. Again, this statistic is only what has been reported!

National Data Relative to all Suicides

A study of suicides nationwide over the last 25 years has shown that:

1. For every completed suicide there are an estimated ten attempts.

2. Even though females attempt suicide more frequently than males, males succeed more often.

3. The majority of suicide attempts are usually between the hours of 3:00 p.m. and midnight.

4. Most attempts take place in the home within earshot of parents or spouses and where there is a good chance of rescue and recovery.

APPENDIX B
ASSESSING SUICIDE POTENTIAL IN THE CLASSROOM

In discussion with Ms. Sattem regarding the tool, she brought out several factors in using the tool.

1. THERE IS NO SET SCORE THAT MAKES A TEENAGER more or less suicidal. A student can be high risk with a low score. The risk has more to do with the intensity and duration of problems and the unique characteristics of the student.

2. It is necessary to validate this tool in different contexts. A student may behave differently in different classes and in different situations.

3. It has been useful when more than one teacher has assessed the same student. There seems to be a higher score when more than one assessor uses the tool.

4. It has been suggested that one person at your school (preferably from crisis team) be responsible for all assessment tools.

This is a CONFIDENTIAL document and may be used only for the purpose of assessing depression and suicidal potential. This form must be kept in a secure place and discussion of the form outside the professional scope of the educator is inappropriate. You will be contacted as to the outcome of this assessment.

Student_____ Grade_____ Date_____

Teacher: Please circle the frequency of the behaviors that this student is exhibiting.

Frequency Key: (1) - ONCE (2) - TWICE (3) - OR MORE

BEHAVIOR	FREQUENCY	ACADEMIC	FREQUENC
Sleeping in class	1 2 3	Grades failing markedly	1 2 3
Class clown	1 2 3	Handwriting worsening	1 2 3
Destruction of property	1 2 3	No effort	1 2 3
Breaking up of boy/girlfriend	1 2 3	Lack of preparation for class (pencil, paper, books)	1 2 3
Lethargic behavior	1 2 3	Work incomplete/missing	1 2 3
Obscene language/gesture	1 2 3	Academic failure	1 2 3
Reluctance to communicate	1 2 3	Extreme dissatisfaction with school	1 2 3
Defensive attitude	1 2 3	Irresponsible behavior	1 2 3
Withdrawn/seclusion	1 2 3	Not staying on task/always behind	1 2 3
Crying	1 2 3	Lack of motivation	1 2 3
Impulsiveness	1 2 3	Other: _____	1 2 3
Depression	1 2 3	PEERS	FREQUENC
Mood swings	1 2 3	Dropping of friends	1 2 3
Sudden outbursts	1 2 3	Peer exclusion	1 2 3
Inconsistent behavior	1 2 3	Avoidance of peers	1 2 3
Delusions or hallucinations	1 2 3	Other: _____	1 2 3
Memory loss/disorientation	1 2 3		

Paranoia (student feels persecuted, picked on)	1 2 3
Other: _____	1 2 3

APPEARANCE/HEALTH	FREQUENCY
Undiagnosed health problems	1 2 3
Neglect of personal appearance	1 2 3
Weight loss or gain	1 2 3
Suspected abuse of drugs/ alcohol	1 2 3
Other: _____	1 2 3

FAMILY	FREQUENCY
Suffered recent loss (moved, divorce, death)	1 2 3
Troubles in family (financial, emotional, health, separation, etc.)	1 2 3
Other: _____	1 2 3

ATTENDANCE	FREQUENCY
Excessive absences	1 2 3
Asking to leave room often (nurse, counselor, restroom, other)	1 2 3
Truancy (all day)	1 2 3
Wandering in halls	1 2 3
Tardiness to class	1 2 3
Cutting classes	1 2 3
Leaving the room early	1 2 3
Other: _____	1 2 3

OVER WHAT PERIOD OF TIME HAVE YOU OBSERVED THESE BEHAVIORS? _____

_____

_____

Teacher's Signature

This assessment tool is reprinted here through the courtesy of Linda Sattem, Executive Director, Suicide Prevention Center, Inc., 184 Salem, Dayton, Ohio 45406, 513/233-9096.

REPORT OF SUICIDE RISK

School _____ Date _____

Student Name _____ D.O.B. _____

Address _____ Parent notified Yes ___ No ___

Parent's Name _____ Date of notification _____

Telephone Number _____ Time _____

Staff Members Involved:

_____ _____

_____ _____

_____ _____

Presenting Problem: Level of Risk: _____

_____

_____

_____

_____

_____

Recommendations:

_____

_____

_____

_____

_____

Results of Parental Contact:

_____

_____

_____

APPENDIX C

In his book Getting Tough on Gateway Drugs, Robert L. DuPont, Jr., M.D., points out that parents forget that:

> "...the period of adolescence is a part of childhood and not part of adulthood. This means that parents have not only the right but also the responsibility to set limits on their child's behaviors, behaviors ranging from allocation of study time, to conforming to curfews, to the use of alcohol and other drugs."

His concern is that "too many parents have given their children too much responsibility for their own behavior. Too many teenagers are treated by their parents (and expect to be treated by their parents) as 'Pseudo-Adults' who have the rights and independence of adulthood but without the responsibilities that go with the status." He adds that some parents are "enabling" their children towards substance abuse beginning at an early age by rescuing them from the consequences of their misbehavior. Consequently, Doctor DuPont says, "too many American young people in their 20s and 30s are still being treated as 'Pseudo-Children' by their well-meaning but misguided parents who try to protect them from the consequences of their misbehaviors and rescue them from their self-centered and often illegal messes."

While some parents argue that children need to learn to be adults by making their own decisions, Doctor DuPont counters by saying "...kids need to learn to be adults, but not by doing anything and everything they please...an intelligent parent does not teach a three-year-old the dangers of crossing the street by 'letting her learn for herself' any more than a parent should teach a 16-year-old about the dangers of drug use by 'letting him learn for himself.'"

In addition, some parents believe they are being good parents if they don't require their children to participate in or contribute to family life by doing chores. In effect, what they are doing is robbing their children of the opportunity to be useful, needed, and responsible members of the family."

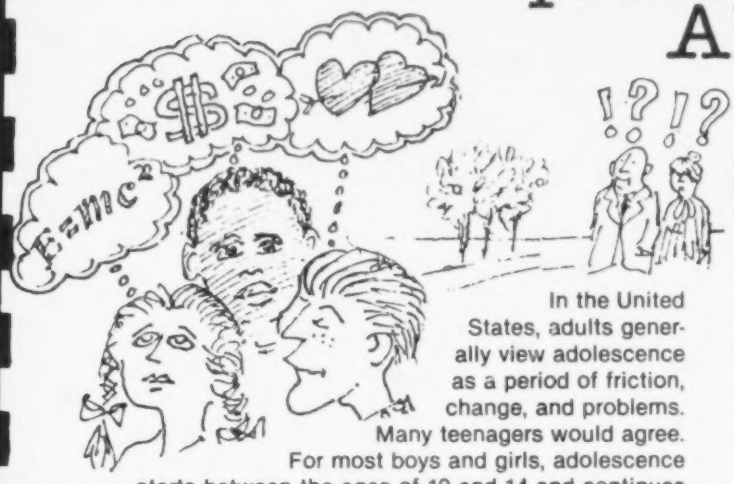
Doctor DuPont explains that:

> "Firm parental control leads eventually to teenage self-control... whatever freedom we eventually exercise is largely an earned freedom which exists almost exclusively in the context of detailed rules of family and community life. Adolescence is a time of earning this much-cherished freedom of choice, but even that freedom, as adulthood so frequently and dramatically demonstrates, is hedged in by people and regulations and limitations beyond the individual's control. It is through directing this earning and learning and this slow realization process that true parental guidance should come naturally and powerfully into play."

(Because DuPont's quotations here are without benefit of a full explanation of his thoughts, the reader is encouraged to read his book in its entirety. Another excellent book is Drugs, Drinking and Adolescents, by Dr. Donald Ian MacDonald.)

APPENDIX D

plain talk about ADOLESCENCE



In the United States, adults generally view adolescence as a period of friction, change, and problems. Many teenagers would agree. For most boys and girls, adolescence starts between the ages of 10 and 14 and continues to between 19 and 21.

For the teenager, it is a time of concern about acne, weight problems, menstruation, late development, early development, sexual arousal, school pressures, boredom, parental hassles, peer pressures, and money problems.

It is a time of confused feelings, particularly in relationships with parents. Teenagers fight for independence yet fear too much freedom; they resent overprotection but need and want parental attention.

For parents, it is a challenge to keep a balanced perspective on their teenager's emotional roller coaster ride. As their children bounce back and forth between childhood and adulthood, alternating irresponsibility with responsibility, blatantly testing parental authority one moment and depending on it the next, parents often do not know what to expect. They must maintain needed discipline, yet they understand their teenager's growing need for independent action, even for rebellion.

It's easy to understand why many parents and adolescents find this such a difficult period to "survive." But, once it is over, even the most rebellious child often becomes appreciative, affectionate, and devoted. With maturity comes the realization that much of their parents' behavior, once so irritating, was motivated by feelings of love for them. Also, having children of their own brings understanding of the pressures their parents faced.

Parents should also be aware of their own imperfections. At times, lack of knowledge, poor advice, community pressures, or their own stresses can cause them to overreact to teenage behaviors. To avoid making the same mistakes as their parents, or to make up for what they missed in their childhood, parents sometimes make mistakes themselves.

Adolescence is a trying period, but it is also an exciting one. If parents and teenagers keep tuned in to each other, this period may seem less trying and more fun for everyone.

How Parents Can Help Keep Communications Open*

When asked about their problems with parents, teenagers most often cite "not being listened to." Really listening is not always easy. Nor is communicating. Some of the following suggestions may help.

Give your undivided attention when your teenager wants to talk to you. Don't read, watch TV, fall asleep, or make yourself busy with other tasks.

Try to listen calmly, even though there may be a difference of opinion. Concentrate on hearing and understanding your teenager's point of view. Don't start preaching when a give-and-take discussion is wanted.

Develop a courteous tone of voice in communication. Respect brings respect—even in the way we speak. If we talk to our offspring as we talk to other people, our own youngsters might be more likely to seek us out as confidants. Gruffness or abruptness can arouse hostility, whereas a pleasant tone of voice can pay great dividends in improved relationships.

Avoid making judgments. Anyone avoids confiding in someone who is critical of his or her behavior. It is not necessary to approve all of your teenager's behavior, but it is important to understand the feelings involved. Putting yourself in another's place is not easy, particularly as attitudes, pressures, and choices change. It is a challenge for a parent to be firm about important values while being flexible enough to bend with changing times.

Keep the door open on any subject. Too often teenagers avoid discussing things that may make their parents feel uncomfortable. Belittling, humiliating, and laughing at youngsters can cause deep wounds and short circuit the lines of communication. Teenagers often pay a very high price for not having the right information about many subjects, including sex.

Permit expression of ideas and feelings. Many young people have their own ideas about morality, marriage, work, education, time, money, and whatever else is a part of our way of life. Just because their views and philosophies are different from yours does not mean that they feel certain about them. Often young people "test" their ideas in conversation. To communicate, you must be willing to listen first and acknowledge their opinions, even if you are alarmed by them. Then give your viewpoints as plainly and honestly as you can, recognizing that love and mutual respect can exist, even when points of view are different.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES • Public Health Service • Alcohol, Drug Abuse, and Mental Health Administration
5600 Fishers Lane, Rockville, Maryland 20857

Encourage positive self-worth. Help your youngster build confidence by encouraging (but not forcing) participation in sports, music, art, dance, or any other hobby or interest.

Be aware of how you treat other children in the family. Do you show favoritism? This could make a child feel rejected, unloved, and jealous. Try to be fair and consistent. It will pay off.

Make an effort to say nice things. Too often parents tend to focus on poor performance and behavior. Every human being needs acceptance and appreciation.

Hold family conferences. Most teenagers feel they have little or no voice in family affairs. Family gatherings offer an excellent opportunity for children to participate in decisionmaking and to work things out together.

HOW TEENAGERS CAN HELP

What responsibilities does a teenager have in trying to bridge the generation gap? The following code of communication was formulated with the assistance of both young people and adults:

"The first barrier to communication which I must cast aside is the attitude of ignoring anybody over 30-years-old. If I expect my parents to tune in to me, then I must be willing to talk to them."

"Our generation wants *understanding* from our elders. In turn, it is only fair that we try to understand them – they have needs and feelings and reasons for their decisions."

"I will listen to my parents with an open mind and look at the situation from their point of view. That's the way I would expect them to treat me."

"I will share more of my feelings with my parents. They may have experienced some of the same problems. I need to give them a chance to help me."

"I want my parents to express trust and confidence in me, to grant me more freedom and responsibility as I mature. It is necessary, then, that I live up to their confidence. What I do reflects on them, and they are held accountable for my actions and behavior."

"Exercising the right to criticize my family, school, or government includes the responsibility to suggest how practical improvements can be made."

"To promote better communication in the family, I will practice courtesy and consideration for others. I will let my parents know I care about them. They are affected by pressures and problems of everyday living just as I am. I will try to cheer them up when they need a lift."

Some Extra Tips to Parents

In addition to improving communication, there are actions parents can take to help their adolescent through the teenage years. The old saw, "actions speak louder than words," is particularly appropriate where parental influence on children is concerned.

1. *Try to set a good example.* Children learn by what they see. Too often people say one thing and do another. "Do as I say and not as I do," will not carry much weight. Eventually children will ask such questions as "What's wrong with smoking pot when my parents get stoned on alcohol?"
2. *Supervise and guide.* Although teenagers are capable of handling certain privileges and responsibilities, they still need help in setting limits on their freedom and behavior. Deciding *with* the teenager what these limits and policies are usually elicits more reasonable attitudes. Moderate and selective guidance is one of the best ways to prevent a breakdown of communication.
3. *Communicate, in words and actions, what you expect of your children.* Although teenagers may appreciate a share in some decisionmaking, they do not want parents to give up authority or to be wishy-washy. Parents who appear confused about firmness and discipline, who are inconsistent, or who disagree between themselves can be perceived as weak and divided. Teenagers need the security of knowing where their parents stand and what parents expect of them.
4. *Respect the adolescent's desire for individuality and independence.* Parents do, and should, attempt to influence their children, but this is quite different from trying to force them into preconceived molds to fit parents' desires. Parents can accept and respect their teenagers as individuals without accepting all their ideas. The reverse is also true; teens can maintain respect for parents while rejecting some of their beliefs. One expert in family problems suggests that parents assume the role of watchful bystanders, ready to come forward when help is needed.
5. *Take an interest in your children's activities and friends.* This helps to reduce the distance between the generations, since it demonstrates your acceptance of their world. Give the youngsters time to be with their friends and make their friends welcome when they come to visit. Taking an interest in your children's activities and friends does not mean taking on the role of friend or invading your child's privacy. Teenagers need separateness and privacy just as parents do.
6. *Try not to overreact.* Many parents brace themselves for the onslaught of adolescence, convinced that it is bound to be a long, hard struggle. Consequently, they are quick to overreact the first time their teenager steps out of line. They punish severely, withdraw trust, and lose confidence in the youngster, thus severing the lines of communication. It is only natural for adolescents to test their parents' authority while trying to assert themselves. At the same time, they are trying out their own competence. Parents must let their children make mistakes – and at the same time be ready to help when help is needed.

It is not realistic to expect complete harmony between the generations. Nor is it pleasant to live through a period of bickering and strain, no matter how temporary. When both parents and teenagers make efforts to communicate and respect each other, adolescence can be an exciting period of discovery for all concerned.

*Also available from the Consumer Information Center, Pueblo, Colorado 81009: *An Adolescent in Your Home*, 105J, $1.00, 27 pp, 1978, on physical and emotional needs and problems of adolescents, areas of conflict, and ways to promote understanding. The section "How Parents Can Help Keep Communications Open" was adapted from Public Affairs Pamphlet No. 438, "Parent Teenager Communication: Bridging the Generation Gap," available for $.50 from the Public Affairs Committee, Inc., 381 Park Avenue South, New York, NY, 10016.

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APPENDIX E
SOURCES OF INFORMATION

Organizations

Sources of help are readily available in local communities for troubled teens and their families. Check the yellow pages for the numbers of suicide hot-lines, suicide and crisis centers, and community mental health centers. During business hours, the American Association of Suicidology (303-692-0985) will provide a referral to the closest suicide crisis center in your area.

The following national organizations can supply information on suicide prevention. (Please send stamped, self-addressed business envelopes with your requests.)

American Academy of Child Psychiatry, 3615 Wisconsin Avenue, N.W., Washington, DC 20016.

American Association of Suicidology, 2459 South Ash, Denver, CO 80222.

American Psychiatric Association, 1400 K Street, N.W., Washington, DC 20005

National Association of Social Workers, 7981 Eastern Avenue, Silver Springs, MD 20910.

National Committee for Youth Suicide Prevention, 230 Park Avenue, Suite 835, New York, NY 10169.

National Mental Health Association, 1021 Prince Street, Arlington, VA 22314.

National Peer Counseling Association, Unit of Educational Development, Bradley University, Peoria, IL 61625.

Suicide Research Unit, National Institute of Mental Health, Room 101C26, 5600 Fishers Lane, Rockville, MD 20857.

School Suicide Prevention Materials

The following groups have developed suicide prevention materials for schools and will provide publication lists upon request. Educators should also check with local suicide prevention centers and community mental health centers for ideas and program guides.

American Association of Suicidology, 2459 South Ash, Denver, CO 80222.

Bergen Regional Counseling Center, 395 Main Street, Hackansack, NJ 07601.

Cherry Creek Schools, Department of Mental Health Services, 3301 South Monaco, Denver, CO 80222.

Fairfax County Public Schools, Belle Willard Administration Center, 10310 Layton Hall Drive, Fairfax, VA 22030.

New York State Council on Youth Suicide Prevention, c/o Lieutenant Governor's Office, State Capitol, Albany, NY 12224.

Plano Senior High School, 2200 Independence Parkway, Plano, TX 75075.

The Samaritans, 500 Commonwealth Avenue, Boston, MA 02215.

San Mateo Suicide Prevention and Crisis Center, 1811 Trousdale Drive, Burlingame, CA 94010.

Suicide and Crisis Center, 2910 Swiss Avenue, Dallas, TX 75204.

Suicide Prevention Center, Inc., 184 Salem Avenue, Dayton, OH 45406.

Books

Alvarez, A., The Savage God: A Study of Suicide. New York: Random House, 1972. (o.p.)

Anderson, Luleen S., Sunday Came Early This Week. Cambridge, Massachusetts: Schenkman, 1982.

Cain, Albert C., ed., Survivors of Suicide. Springfield, Illinois: Charles C. Thomas, 1972.

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Rosenfeld, Linda and Prupas, Marilynne, Left Alive: After a Suicide Death in the Family. Springfield, Illinois: Charles C. Thomas, 1984.

Shneidman, Edwin S., ed., On the Nature of Suicide. San Francisco: Jossey-Bass, 1969.

Shneidman, Edwin S. and Farberow, Norman L., eds., Clues to Suicide. New York: McGraw-Hill, 1957.

Sudak, Howard S.; Ford, Amasa B.; and Rushforth, Norman B., Suicide in the Young. Littleton, Massachusetts: PSG Publishing, 1984.

Films & Videotapes

Adolescent Suicide: A Matter of Life and Death. American Association for Counseling and Development, 5999 Stevenson Avenue, Alexandria, VA 22304.

Childhood's End: A Look at Adolescent Suicide. Filmakers Library, 133 East 50th Street, New York, NY 10022.

Did Jenny Have to Die: Preventing Teen Suicide: You Can Help. Sunburst Communications, 39 Washington Avenue, Room GN-2, Pleasantville, NY 10570.

Inside, I Ache. Mass Media Ministries, 2116 North Charles Street, Baltimore, M.D 21218.

The Last Cry for Help. (A Learning Corporation of America Film.) Simon & Schuster Communications, 108 Wilmont Road, Deerfield, IL 60015.

Sudden Adolescent Death. Human Relations Media, 175 Tompkins Avenue, Pleasantville, NY 10570.

Suicide at Seventeen. Lawren Productions, Inc., P.O. Box 666, Mendocino, CA 95460.

Survivorship After Suicide. Ray of Hope, P.O. Box 2323, Iowa City, IA 52244.

Teenage Suicide. (An MTI Teleprograms, Inc., Film.) Simon & Schuster Communications, 108 Wilmont Road, Deerfield, IL 60015.

Teenage Suicide: Is Anyone Listening? Barr Films, 3490 East Foothill Boulevard, Pasadena, CA 91107.

Teenage Suicide. Films Incorporated, 8124 North Central Park Avenue, Skokie, IL 60076.

Surviviors of Suicide Resources

After Suicide: A Unique Grief Process by Eleanora "Betsy" Ross (booklet). Ray of Hope, Inc., P.O. Box 2323, Iowa City, IA 52244.

Afterwords (newsletter). Adina Wrobleski, 5124 Grove Street, Minneapolis, MN 55436.

The Care of the Suicide Survivor: A Model for Funeral Home Personnel, A Model for Clergy, A Model for Coroners and Medical Examiners (booklets), and The Ultimate Rejection (newsletter). Suicide Prevention Center, Inc., 184 Salem Avenue, Dayton, OH 45406.

My Son, My Son ... A Guide to Healing After a Suicide in the Family by Iris Bolton and Curtis Mitchell (book). Bolton Press, 1325 Belmore Way, N.E., Atlanta, GA 30338.

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APPENDIX F

The first National Conference on Youth Suicide occurred on June 19-20, 1985. Some of the nation's leaders in the area of youth suicide were speakers.

- Youth Suicide National Center
  1825 Eye Street, N.W., Suite 400
  Washington, DC 20006
  202/429-2016

  This organization is serving as a clearing house for the dissemination of information on youth suicide.

- National Hot Line on Youth Suicide
  1-800-621-4000

- There are two videocassette programs on youth suicide from CBS Educational and Community Services, "Is Anyone Listening?" (November 1984), and "Hearing Between the Lines" (February 1985). The videos can be obtained by contacting the Youth Suicide National Center (see above).

- There is a wealth of information regarding problems of children and youths. Request a Subject Biography from:

  U.S. Government Bookstore
  World Savings Building
  720 North Main Street
  Pueblo, CO 81003

- Social Issues Resource Series, Inc.,
  8141 Glades Road
  Boca Raton, FL 33432

  This resource has a series of articles from current periodicals and newspapers that have been selected for classroom use as a basis for discussion. The resources are selected for relevancy, objectivity, and interest to high school students. In teaching about adolescent suicide, several volumes can be useful:

  Death and Dying, Vol. I. Articles 11, 50, 24, 54, 59, and 61

  Death and Dying, Vol. II, Articles 2, 14, 3, 19, 18, and 11

  Youth; Vol. I, Articles 6, 9. 14, 15, 17, 18, 39, 45, 54, 63, 72, 77, 79, and 81

  Youth, Vol. II, Articles 8, 11, 12, 19, 20, 21, and 23

- The Institute for Studies of Self-Destructive Behaviors and the Suicide Prevention Center
  1041 South Menlo Street
  Los Angeles, CA 90006
  213/381-5111

- Merck, Sharp and Dohme
  Health Information Services
  West Point, PA 19486
  215/661-5000

- National Institute of Mental Health
  Mental Health Emergencies Section
  5600 Fishers Lane
  Rockville, MD 20852
  301/443-4515

APPENDIX G
EVALUATION FORM

Send to: Josephine Osborne, R.N., M.S.N.
Indiana State Board of Health
Room 232
1330 West Michigan Street
Indianapolis, IN 46206-1964

Please take a few moments to complete this form and return it to the above address. We consider this document to be a beginning approach to the manual on youth suicide. Your candid opinions will help us make future editions more beneficial.

1. Has this manual given you a better understanding of the phenomenon of suicide?

1	2	3	4	5
NOT HELPFUL	MODERATELY HELPFUL			VERY HELPFUL

2. Has this manual helped you understand and recognize adolescent depression?

3. Has this manual helped you understand substance abuse and its relationship to depression/suicide?

4. Has this manual helped you identify the potentially suicidal adolescent?

5. Has this manual helped you in planning for suicide prevention programs?

6. Has this manual helped you in planning for your school's response to a suicide?

7. What have you found most helpful about the manual?

_____

_____

_____

8. What have you found least helpful about the manual?

_____

_____

_____

9. How would you recommend the manual be improved?

_____

_____

INDIANA STATE BOARD OF HEALTH